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ABSTRACT

The Comprehensive Child Development Program (CCDP), enacted by Congress in 1988, provides intensive, comprehensive, integrated, and continuous support to preschool children from low-income families to enhance their intellectual, social, and physical development. It also provides needed services to parents and household family members to enhance their social and economic self-sufficiency. This interim report, covering the period from September 1989 through March 1993, reports on the progress of 34 program demonstration grantees serving 3,300 families. In Part 1, Chapter 1 describes the history, start-up activities, components, policy questions, feasibility analysis, process evaluation, and impact evaluation of the CCDP program. Chapter 2 describes the CCDP families projects included in the report. Chapters in Part 2 of the report analyze the feasibility (development and structure) and process evaluation (issues of individual and family goal attainment) of CCDP. Chapter 3 gives the conceptual framework and evaluation methods. Chapters 4 through 8 provide evaluation results, covering project life cycles, attrition, family satisfaction, use, goal attainment, community effects, and cost contain a sample case management goal and action plan, CCDP management information system codes children, parents, and families. Chapter 9 presents the conceptual framework and study methods. Results of parent and family outcomes are given in Chapter 10, and results of child outcome are given in Chapter 11. Chapter 12 summarizes the philosophy of CCDP and contains summaries of the feasibility analyses and evaluations. Overall, the report concludes that the CCDP projects--although not easy to implement--are viable and are helping families take positive steps to achieve their goals. Most chapters in the report include references. Three appendices contain a sample case management goal and action plan, CCDP management information system codes for recording different types of services, and a description of the impact evaluation sample. A separately-published 15-page "Executive Summary" has been appended. (TM)

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ED 373 873

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Head Start Bureau

Comprehensive Child Development Program—A National Family Support Demonstration

INTERIM REPORT TO CONGRESS

March 1994

Report of the Secretary
Department of Health and Human Services
To the Congress of the United States

PS 022528

BEST COPY AVAILABLE

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Head Start Bureau

COMPREHENSIVE CHILD DEVELOPMENT PROGRAM—A NATIONAL FAMILY SUPPORT DEMONSTRATION

INTERIM REPORT TO CONGRESS

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U.S. Department of Health and Human Services

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 2020

MAY 6 1994

The Honorable Edward M. Kennedy
Chairman, Committee on Labor
and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Section 670N [42 U.S.C. 9881] (f) of the Comprehensive Child Development Centers Act, as amended, requires that the Secretary of the Department of Health and Human Services submit a report to the Congress concerning the results of the evaluation of the projects funded under the Act in order to determine their effectiveness in achieving stated goals, their impact on related programs, and their structure and mechanisms for the delivery of services.

The Comprehensive Child Development Program (CCDP), authorized under the Act, is required to provide intensive, comprehensive, integrated and continuous support services to children from low-income families from birth until entrance into elementary school to enhance their intellectual, social and physical development; and to provide needed support services to parents and other household family members to enhance their social and economic self-sufficiency.

Enclosed is the mandated report, delivered as an interim report, with the final report being scheduled for delivery to the Congress in March 1996. This extension is needed to allow currently enrolled families to receive the required five years of services and thus enable the Department to provide a sound assessment of the complete impact of the CCDP on the lives of these families and their children. The interim report covers the period from September 1989 through March 1993, which includes the start-up year and two-and-one-half years of service delivery to families.

I am pleased to submit the Interim Report to Congress: Comprehensive Child Development Program -- A National Family Support Demonstration.

Sincerely,

Donna E. Shalala

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON D.C. 20201

MAY 6 1994

The Honorable William D. Ford
Chairman, Committe on Education
and Labor
House of Representatives
Washington, D.C. 20515

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Sincerely,

Donna E. Shalala

Enclosure

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PREFACE

The Comprehensive Child Development Act of 1988 was enacted because Congress recognized that low-income families are becoming increasingly vulnerable in today's society and that human services need to reach these families early enough to be effective. These services must be sufficiently comprehensive and sustained over an adequate period of time to make real and meaningful differences in family members' lives. If delivery of these services is not sufficiently comprehensive and intensive, low-income families can and often do feel that they are alone and without adequate supports to contend with increasing pressures and demands.

Human services systems for these families have been criticized historically as categorical, fragmented, and even somewhat disorganized. The focus of these systems has been on achieving singular objectives and serving the needs of some, but not all, family members. Furthermore, the existing public welfare system has been overburdened by severe staff shortages, inadequate resources, and little or no interagency coordination or service integration, making it difficult for family members to access the services that are available. The need to examine an alternative approach to traditional human services delivery has never been more apparent or timely. The Comprehensive Child Development Program (CCDP) has been identified as such an alternative approach.

Conceptually, CCDP embodies the values and ideals of the family support community. Specifically, CCDP does the following:

- Involves the whole family and the whole community in program planning and implementation;

- Establishes a system of networks characterized by peer and staff support;

- Focuses on optimizing child growth and preparing children for later school experiences;

- Prepares parents as significant change agents in their children's development and in their own development;

- Serves as a catalyst for connecting various community and public programs and agencies that deliver specific services;

- Builds upon each family's strengths rather than serving only as a remedy for weaknesses;

- Intervenes early in the life of a child and family and provides continual supports over a sustained period of time; and

- Assists families in meeting goals by working with them to establish relevant and viable paths and a roadmap for progressing along these paths.

At the heart of CCDP is the goal to empower families and family members to better cope with the stresses and anxieties of their daily lives and to achieve goals that are meaningful to them. As Dr. Sharon Lynn Kagan suggests, "We should seek to empower the family as its own unit—making it responsive to its own functionings, as well as to the larger community in which they live and exist."

Dr. Kagan would be the first to admit that this goal is not easily attainable. High mobility, large bureaucracies, and poor access are just some of the factors that make it difficult for low-income families to develop the intricate community linkages that are essential for mutual support and subsequent growth.

What magic does CCDP possess to turn all of this around?

First, CCDP is foremost a family-focused program. Its premise is that families can be empowered to make a real difference in their lives when they set goals which are meaningful to them and which they believe can be achieved. CCDP provides them with the skills and opportunities to enhance and reinforce this belief.

Second, CCDP capitalizes on available opportunities for support and assistance that already exist in communities. The program pulls together and coordinates relevant community and public resources in a manner designed to enhance the availability and quality of these resources.

Third, CCDP encourages and facilitates the participation of a broader base of resources than is typical of existing human services systems. These resources provide accurate, realistic, and user-friendly information, guidance, encouragement, and emotional support to families to facilitate a greater utilization of needed services.

Finally, and more specifically, CCDP provides greater access to services through improved transportation systems; a case management approach for effectively brokering services between families and service agencies; a child development and parent education and training component for enhancing the individual and joint growth of children and parents; and a local advisory board consisting of parents, service providers, representatives of business enterprises, and community leaders who work together as part of a coordinated network for the empowerment of families.

When Congress wrote the Comprehensive Child Development Act, it crafted a demonstration to determine CCDP's feasibility and cost-effectiveness. Congressional intent was for the Department of Health and Human Services to establish an empirical support base for recommending further legislation.

To create a program that encourages both innovation and relevancy in response to the needs of its constituency, the Administration on Children, Youth and Families (ACYF) designed CCDP with the underlying assumption that no single family-support or community-support model can be considered the best. ACYF program designers felt that model effectiveness probably would vary among different communities, family structures, and cultures. Consequently, ACYF did not prescribe specific service delivery models and, instead, allowed each project to develop its own models.

Nevertheless, CCDP's 24 grantees are bound together by a set of similar goals. Although differing in terms of the intensity, frequency, and duration of services and service delivery systems, all projects share the requirements to provide or guarantee the provision of the same set of core services for families. Furthermore, although differing in terms of the philosophy and strategy used to enhance the intellectual, social, emotional, and physical development of children, all projects share a common goal for children to reach their optimum growth potential. Lastly, although differing in terms of the characteristics of their parent involvement initiative, all projects share multiple goals for parents to become more effective educators of their children, to move toward economic and social self-sufficiency, to reduce or eliminate parent dependency on drugs, and to promote the healthy birth and care of their infants.

The CCDP demonstration affords a wonderful opportunity to examine how best to strengthen and empower families. This report will provide readers with an excellent understanding of the progress that CCDP projects have made toward accomplishing this goal.

ACKNOWLEDGMENTS

A project as large as the Comprehensive Child Development Program (CCDP) could not have been accomplished without the input and cooperation of the CCDP projects. Through our continual discussions with CCDP project directors and other staff at national CCDP conferences and throughout the year, we have gained valuable insight into the complex and multifaceted nature of these projects and of the great variation in the types of families served by CCDP.

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Anthony Mannarino from the Western Psychiatric Institute, Vonnie McLoyd from the University of Michigan, David Olds from the University of Rochester, Harold Richman from the University of Chicago, and Neal Schmitt from Michigan State University. Two CCDP project directors serve as representatives on the panel: Sebastian Striefel from the University of Utah and Loretta Alexander of Project Family in College Station, Arkansas.

PART I. INTRODUCTION AND BACKGROUND

Chapter 1. Introduction and Background

Chapter 2. Characteristics of CCDP Families and Projects

Chapter 1. INTRODUCTION AND BACKGROUND

The Comprehensive Child Development Act (Public Law [P.L.] 100-297) was enacted by Congress in 1988. The legislative goals of the act include (1) preventing educational failure by addressing the psychological, medical, institutional, and social needs of infants and young children; (2) decreasing the likelihood that young children will be caught in the cycle of poverty; and (3) promoting educational achievement (Congress, 1987). Specifically, the program is required to provide intensive, comprehensive, integrated, and continuous support services to children from low-income families from birth until entrance into elementary school to enhance their intellectual, social, and physical development and (2) to provide needed support services to parents and other household family members to enhance their economic and social self-sufficiency. The underlying philosophy of the act is that children are an integral part of the larger family unit, and interventions that serve all family members increase effective and productive family functioning and contribute substantially toward children achieving their full potential. Further, the act is based on the belief that (1) interventions with children and parents must occur soon after the birth of the child and (2) the family unit must be served in a comprehensive and integrated manner if the cycle of poverty in which these families are entrenched is to be broken.

P.L. 100-297 also mandated that programs funded under the act must collect data on the groups of individuals and geographic areas served; the data include the types of services to be provided, the estimated costs of providing comprehensive services on an average per user basis, the types and nature of conditions and needs identified and met, and other information as may be required periodically by the Secretary of the Department of Health and Human Services (DHHS).

A total of 24 Comprehensive Child Development Program (CCDP) grantees were funded by DHHS between 1989 and 1990[1] to serve more than 2,500 families. The first 3½ years of operation have been challenging and exciting and have revealed useful information and insights about innovative approaches to providing comprehensive, integrated family support services.

During the first year of funding, the projects engaged in startup activities, including (1) hiring and training of staff members, (2) locating and renovating facilities, (3) developing and refining intervention approaches and models, (4) forming advisory boards, (5) negotiating interagency agreements for services, and (6) recruiting families. Families were enrolled in CCDP toward the end of the first year and during the beginning of the second year. The second and third years of the program have involved providing comprehensive services to families, including assessing their needs, providing ongoing goal planning, and delivering services to enable (1) children to grow in developmentally appropriate ways and (2) families to work toward attaining their goals and eventual self-sufficiency. The second and third years of the program also have entailed monitoring and providing technical assistance to ensure that every project provides all families with the range of comprehensive services that Congress intended under the act.

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[1] An additional 10 CCDP grantees were funded between 1992 and 1993.

The legislation required that DHHS conduct assessments to determine whether the goals of CCDP were met and to report these results to Congress in October 1993. Because families will not finish receiving their required 5 years of services until September 1995, DHHS has requested that the final and more definitive report be delayed until March 1996.

The current report is being delivered as an interim report. It provides descriptive and analytic information—for the period of September 1989 through March 1993 (covering the startup year and 2½ years of service to families)—for 21 of the 24 original CCDP grantees.[2] The report provides a historical review of the development and background of CCDP; describes the components of CCDP; identifies the major policy and research questions addressed by CCDP; furnishes descriptions of the characteristics of families and projects; and provides preliminary findings on (1) attrition and family satisfaction and services utilization, (2) family and individual needs and goal attainment, (3) CCDP's impact on the community, (4) CCDP costs, and (5) CCDP's impact on children and parents.

HISTORY OF CCDP

CCDP is an innovative effort enacted by congress and administered by the Administration on Children, Youth and Families (ACYF). The program's design is based on numerous research studies and previous program efforts in early intervention for children and families. The legislation that enacted CCDP reflects the successful components of these previous efforts, which have been combined to constitute a program that is responsive to families who have multiple social, economic, physical, and educational problems which can hinder their development and prevent them from achieving the full benefits of such interventions (CSR, 1991). The early intervention programs that resulted in the design of CCDP and its components are described below.

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[2] Both evaluations focus on 21 of the initial 24 projects. Two of the projects were excluded because of difficulties in meeting the requirements of the research design and a third project was excluded because insufficient resources were available for evaluation purposes.

Early Intervention Programs That Led to the Development of CCDP

A number of related early intervention programs for children and families in this country have been funded and conducted under the auspices of the Federal Government, first through the Office of Child Development and later through ACYF and private foundations. The largest and most renowned of these early intervention programs is Project Head Start, which began in 1965 as part of the "War on Poverty" and has been a progenitor of numerous demonstration and experimental programs. Head Start serves 3- to 5-year-old children from low-income families and their parents. Head Start is a comprehensive program intended to foster parental involvement and address all aspects of children's lives, including their physical and emotional health and social and intellectual development. Many child development experts recognized, however, that intervention should begin earlier than age 3 in a child's life because deterioration of cognitive and emotional functioning can begin in the first few months of an infant's life (Greenspan, 1981).

In an effort to respond to these concerns, the Head Start program was expanded in 1967 to include comprehensive, early intervention programs called Parent-Child Centers (PCC's) for children from birth to 3 years of age. PCC's were intended to enhance the development of children and strengthen parents as the primary educators of their children by providing low-income families with social services and health and educational assistance. The PCC's design includes providing educational services to children 2 or 3 days a week either through center-based programs, home-visiting services, or a combination of both.

From 1973 through 1978 the Head Start Bureau funded the Child and Family Resource Program (CFRP). This demonstration project provided services to low-income families with children from the prenatal stage to 8 years. As one of the Nation's first family support programs, CFRP operated with the underlying philosophy that children cannot develop optimally in the presence of serious unresolved problems; therefore, the entire family was enrolled in the program. This family-oriented child development program provided continuity through the child's early years by offering the following three components: (1) an infant-toddler component (prenatal through age 3), (2) Head Start (ages 3 through 5), and (3) a preschool linkage component for children making the transition from preschool to elementary school. CFRP emphasized comprehensive assessments, individualized planning, and reassessment for identifying families' needs and providing services to meet those needs. Services provided include health care, nutrition, early education, assistance with housing and employment, marriage counseling, treatment for alcoholism, and other family supports. A key component of CFRP was the home visitor or family advocate, who brokered for the family in obtaining various community services. Although the program was eventually terminated, CFRP influenced the development of many other family support programs, including CCDP (Zigler and Muenchow, 1992).

Another program that influenced the development of CCDP is the Center for Successful Child Development (CSCD), also known as the Beethoven Project. This project began in 1986 under funding from the Harris Foundation. CSCD, located in the Robert Taylor Homes housing project in Chicago, represents a model for community-based prevention and early intervention services. The main goals of CSCD are to promote the healthy growth and development of children prenatally through age 5 and to prepare them for achievement in public schools. CSCD relies on two basic strategies for achieving these goals: (1) gaining the early and continued participation of the community in the planning and delivery of services and (2) using a family-centered rather than child-centered approach.

The programs described above have generated numerous research and evaluative efforts that have assessed the effectiveness of early intervention programs. The literature suggests that these intervention programs are a viable means of promoting child development, fostering parenting skills, and enhancing family self-sufficiency. In addition, the research indicates that intervention efforts for low-income children and their families have the greatest effects if programs accomplish the following:

- Begin at or before birth and continue until entrance into school;
- Provide intensive and comprehensive services;
- Address all developing domains of the child, including intellectual, social, emotional, and physical development;
- Include all family members as program participants;
- Remain firmly grounded in the community in both the planning and implementation stages;
- Coordinate delivery of services with agencies and institutions already serving the community;
- Utilize state-of-the-art delivery strategies and curricula; and
- Have strong transition procedures from the intervention program to the public schools.

All of these components are incorporated into CCDP.

Establishment of CCDP

On July 22, 1987, the Committee on Labor and Human Resources brought before the full Senate a bill that amended the Head Start Act by providing for the establishment of no more than 25 comprehensive child development centers that would provide intensive and comprehensive services to children and families living in poverty. The bill was sponsored by Senator Edward

Kennedy, Chairman of the Committee, and was cosponsored by Senators Brock Adams, Jeff Bingaman, Christopher Dodd, Tom Harken, Spark Matsunaga, Howard Metzenbaum, Barbara Mikulski, Claiborne Pell, Paul Simon, Robert Stafford, and Lowell Weicker. The bill was approved unanimously by the full Senate and was signed into law as the Comprehensive Child Development Act of 1988 (Part E of P.L. 100-297) on April 28, 1988. This act was authorized for 5 years from Fiscal Year (FY) 1989 to FY 1993 at an annual authorization level of $25 million. The Human Services Reauthorization of 1990 extended CCDP to FY 1994 and increased the annual authorization level to $50 million.[3]

The act provided for the establishment of 10 to 25 CCDP projects. According to the law, a wide range of agencies were eligible to implement a CCDP project, including the following: (1) Head Start agencies or those eligible to be designated as such, (2) community-based organizations, (3) institutions of higher education, (4) public hospitals, (5) community development corporations, or (6) any public or private nonprofit agency or organization specializing in the delivery of social services to infants and young children. A *Federal Register* announcement was issued on December 29, 1988, to call for proposals to establish the CCDP projects. The announcement provided application procedures and specified program requirements in greater detail, including the core services to be delivered to families. The act also made funds available for up to 30 planning grants to assist new, small, or economically disadvantaged agencies in applying for the 5-year operating grants. DHHS issued 30 planning grants for a 3-month period and subsequently received 211 applications for operational grant funds to establish CCDP projects. After a highly competitive assessment process to identify those agencies with the greatest potential for working with community groups in delivering services to young children and their families, 22 agencies were funded in September 1989, and 2 additional agencies were funded in April 1990. The 24 CCDP projects which were funded are listed in Exhibit 1-1 following the next page.

The first year following initial funding was designated as a startup period for the program, during which grantees were to accomplish the following: (1) hire and train all project staff, (2) obtain facilities, (3) familiarize the community with the goals and purposes of CCDP, (4) negotiate interagency agreements to provide contractual services, (5) recruit all families, and (6) begin to deliver services. In actuality, some projects that were not fully implemented by September 1990 extended the startup period beyond 1 year.

By the middle of 1991, all 21 projects reported on herein were implemented and operational, providing the full range of core services to CCDP family members. Although the act does not define a particular service delivery system to which grantees must adhere, it does mandate that certain core services be provided at a minimum specified level. This is mandated in order to enhance both the intellectual, physical, and emotional development of children and the family's economic and social self-sufficiency. All contacts and services, whether provided by CCDP or another agency, must be recorded and entered into the management information system (MIS) developed specifically for CCDP. By October 1991, the MIS was fully implemented at all projects.

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[3] Congress increased the current appropriation level to $44.4 million beginning in FY 1992 and $46.8 million beginning in FY 1993 with the request that additional grantees be funded. Ten new CCDP grantees (Cohort II) were, in fact, funded in FY 1992 and FY 1993.

Components of CCDP

The core services for children and adult family members embodied in the act and further clarified in the December 29, 1988, *Federal Register* announcement and subsequent ACYF administrative program instructions and notices are described below.

Early Childhood Education/Early Intervention/Child Care

This component embodies the following services and related standards:

- Developmental screenings and ongoing assessments must be completed for all children in the program family who are under compulsory school age.

- An individualized development plan must be written for all children under school age in the family, based on the findings of the screenings and assessments.

- Children who are identified as being at risk or developmentally delayed must have timely access to an early intervention program.

- An appropriate developmental curriculum/curricula must be identified by each program. Staff members who implement the curriculum must be trained adequately.

- An appropriate child development experience must be provided for each CCDP family member under school age. If these experiences are center based, they must be provided at least 3 days per week and meet the Head Start Performance Standards. If these experiences are home based, they must be provided at least 1 day per week. Home-based interventions must focus on the primary caregiver as the primary educator of the child.

- Child care must be available and accessible to any parent requesting it when the primary caregiver is in training or employed.

- Child care centers, family day care homes, and child development centers must meet State licensing standards or certification. If the

Exhibit 1-1

The 24 CCDP Cohort 1 Projects Funded by DHHS

Project AFRIC Dimock Community Health Center Roxbury, MA	Tennessee CAREs Bureau of Educational Research and Services Tennessee State University Nashville, TN
Windham County Family Support Program Brattleboro Town School District Brattleboro, VT	Project Focus Grand Rapids Child Guidance Clinic Grand Rapids, MI
Project CHANCE Project Teen Aid Brooklyn, NY	West CAP Full Circle Project Western Wisconsin Community Action Agency Glenwood City, WI
Parent-Child Resource Center Edward C. Mazique Parent Child Center Washington, DC	Project Family Arkansas Children's Hospital College Station, AR
Family Start Friends of the Family, Inc. Baltimore, MD	Families Partnership CCDP City of Albuquerque Albuquerque, NM
Family Foundations Community Human Services University of Pittsburgh Pittsburgh, PA	Primero Los Ninos La Clinica de Familia Las Cruces, NM
Toddlers, Infants, Preschoolers, and Parents Dade County Community Action Agency Miami, FL	Avance CCDP Avance, Inc. San Antonio, TX
Operation Family Community Action Council of Lexington-Fayette, Bourbon, and Nicholas Counties Lexington, KY	ShareCare Program Day Care Association of Fort Worth and Tarrant County Ft. Worth, TX
Comprehensive Child Development Program Mid-Iowa Community Action Marshalltown, IA	Community-Family Partnership Project Center for Persons With Disabilities Utah State University Logan, UT
Project EAGLE University of Kansas Medical Center Kansas City, KS	Conocimiento Southwest Human Development, Inc. Phoenix, AZ
Family Futures Clayton Foundation and Mile High Child Care Denver, CO	ENRICH Venice Family Clinic Venice, CA
Little Hoop CCDP Little Hoop Community College Fort Totten, ND	Families First Children's Home Society of Washington Auburn, WA

center is providing the early childhood educational experience as well, the center also must meet relevant Head Start Performance Standards, including the following:

- — Baselines for adult-child ratios or group size;
- — Daily and weekly schedules;
- — Developmentally appropriate toys, equipment, and curricula;
- — Culturally relevant materials and staff;
- — Training for staff on utilizing a developmentally appropriate curriculum; and
- — A documented mechanism to ensure that activities in center-based care or family day care homes will interface with developmental activities provided at home.

Health

Core health services for children and adults are listed below:

Children

- Health screenings and a comprehensive health assessment for children must be completed.
- Immunizations which are appropriate for each child's age must be available, brokered, and monitored.
- Well-baby/child health care must be available, brokered, and monitored.
- Acute health care must be provided when needed.
- Mental health care must be provided when needed.

Adults

- Prenatal and postpartum care must be available, brokered, and monitored.
- Routine and acute health care must be provided as needed.
- Therapeutic mental health care must be provided as needed.
- Preventive mental health care must be provided.

- Substance abuse education and treatment must be provided when needed and monitored.

- Special Supplemental Food Program for Women, Infants and Children eligibility and/or other nutritious food sources must be available, brokered, and monitored.

Parent/Adult Education and Training

This component embodies the following services and related standards:

- Training must be provided to primary caregivers in parenting skills, health care, nutrition, and life skills/functioning (e.g., budgeting). This training may be provided through CCDP center-based or home visitor training or through a contracting/interagency agreement if the training is accessible to parents, and procedures have been established to monitor the training.

- Adult literacy education, vocational training, employment counseling, job training/placement, and furthering educational achievement must be available to all program families requesting these services. Services arranged through contracting agencies must be accessible and provided in a timely manner.

- Linkages with major employers or agencies for findings jobs for family members are to be established.

Male Involvement

This component includes the following:

- Specific efforts to increase male participation and/or involvement in the program are to be made.

Case Management

This component, a cornerstone of CCDP, includes the following:

- Agency staff and participants must complete a family needs and goals assessment for each family every 6 months.

- Agency staff and participants must complete a family service plan for each family member every 3 months. Services should be related closely to the assessed needs and goals.

- All families must receive at least a weekly case management home visit.

- Case managers must broker (and not merely refer) services for families.

- Families must receive assistance with social services, including housing and income support.

Administration

Successful implementation of this component includes meeting the following requirements:

- Program and comparison groups must be selected randomly.
- Written interagency agreements must exist with all relevant agencies.
- Adequate transportation must be provided to all family members to ensure access to core services.
- The level of core services provided must be consistent with established developmental, health, and nutritional practices for children and Head Start Performance Standards (45 CFR Subchapter B, Part 1304, Subparts B, C, D, and E, excluding Appendixes A and B).
- Each program must have an advisory board that meets at least quarterly (committees should meet more frequently) with representatives from program parents, agencies, community and public leaders, experts representing the services the project provides, and local employers or businesses.

The act did not intend for grantees to provide many of these services directly—unless they are unavailable or of an unacceptable quality in the community—but rather it encourages coordination with and utilization of existing community services in order to make these services work better for families. Projects are expected to secure written, signed interagency agreements describing the services to be provided by cooperating agencies.

Overall, the objectives of CCDP require that local projects organize the range of extant human services in the community to benefit program families, as well as develop those services that the project must provide itself if they do not exist in the community. Each project is to build collaborative relationships with other community and public service agencies to form an integrated service system for program families. The types of interagency arrangements and agreements made by local projects are discussed later in this report.

CCDP POLICY QUESTIONS

A list of the major policy questions addressed in the CCDP demonstrations is presented in Exhibit 1-2 following the next page. Many of these questions are addressed in this report, and all others will be covered in the final report. Because CCDP was designed as a 5-year service program, answers to questions provided at this time only reference short-term outcomes and must be considered tentative with regard to implications for longer term outcomes. Clearly, any answers given now must be validated after the projects have had the opportunity to complete all 5 years.

In order to address these policy questions, the act requires that an evaluation be conducted and a report be submitted to Congress by the Secretary of DHHS on the effects of CCDP accompanied with recommendations for future program implementation. ACYF selected third-party contractors to assist in the management and evaluation of CCDP. CCDP's technical assistance and the feasibility analysis and process evaluation were separated from the impact evaluation to ensure the integrity of both program evaluation components. Hence, two Request for Proposals were issued by ACYF—one to conduct the feasibility analysis and process evaluation and to provide management support for the program and the other to conduct the impact evaluation of CCDP's effects on children and families. ACYF competitively selected CSR, Incorporated, and its subcontractor, Information Technology International, as the management support and feasibility/process evaluation contractor and Abt Associates Inc., as the impact evaluation contractor.

FEASIBILITY ANALYSIS AND PROCESS EVALUATION

The feasibility analysis and process evaluation addresses two broad areas regarding the implementation of CCDP. The first area focuses on issues in the development and structure of CCDP projects that relate to feasibility. These issues include startup, development, community resources and support, family characteristics, the grantee agency, organization of service delivery developed through interagency linkages, the costs of service delivery, and program adaptation over the duration of the project. The second area focuses on issues that relate to attaining of individual and family goals, including family utilization patterns, service content, availability of services, the organization of CCDP projects, family attrition, the impact of CCDP on the community, and service integration. Although issues of feasibility and goal attainment are related, they require separate analyses in the evaluation. The conceptual framework for the feasibility analysis and process evaluation is presented in Part II, Chapter 3, of this report.

The primary sources of data for the feasibility analysis and process evaluation are the automated MIS, cost and budget data, ethnographer reports, information from site visits, and quarterly progress reports (each is discussed in Part II, Chapter 3). Site visits provide crucial information on the status of program implementation at annual intervals. Each project has hired a site ethnographer who provides a detailed case study of the project three times a year (based on ACYF guidance), which describes features in

Exhibit 1-2

CCDP Policy and Study Questions

1. **Are the families enrolled in CCDP those who can benefit the most from a comprehensive, integrated program like CCDP?**

2. **Were programs implemented as planned by the CCDP legislation and administrative guidelines?**

   — What are the characteristics and quality of CCDP projects?

   — What core and noncore services are families receiving? What are the mechanisms used by CCDP projects to provide these services?

   — Is CCDP feasible? How long does it take to successfully implement a CCDP project?

   — How are CCDP project characteristics affected by local community resources and support, the grantee agency, and family characteristics?

   — What are the characteristics of the various coordination/collaboration arrangements used by CCDP projects?

3. **What works, and how, when, where, and why does it work?**

   — Which program components and what levels of duration and intensity are appropriate for particular populations?

   — What are the effects of CCDP on children's cognitive development, socioemotional development, and physical health?

   — Are families satisfied with CCDP? What is the attrition rate and reasons for attrition?

   — What proximal factors (e.g., availability of other services and supports in the community and community beliefs about childrearing) and distal factors (e.g., legislative and funding constraints) influence program effectiveness?

   — What is the extent of parent participation, activity, and goal progress in CCDP?

   — What are the effects of CCDP on parent education, employment, parenting skills, economic self-sufficiency, life management skills, and psychological and physical status?

Exhibit 1-2 *(continued)*

4. **What impact does CCDP have on the community?**

   - Does CCDP facilitate the creation of social supports where they did not formerly exist and strengthen those that existed prior to the implementation of CCDP?
   - Does CCDP have an effect on the characteristics, availability, and quality of local human services and local service delivery networks?
   - What are the barriers and facilitators of services integration at both the service delivery and systems levels?
   - Is there a diffusion of effects of CCDP in the community (i.e., Did non-CCDP families benefit as a result of CCDP implementation?)?

5. **What are the costs of CCDP?**

   - What are the average costs per family and per family member?
   - Are certain components of CCDP particularly expensive?
   - Which factors relate to variations in the cost of program implementation and operation across sites?

the community, the service network, the CCDP project, and families that relate to program feasibility and service utilization and goal attainment.

IMPACT EVALUATION

The impact evaluation is designed to assess multiple areas of CCDP's impact on the development of children, parents, and families in an effort to determine whether the CCDP has had a positive effect. For this study, the effect of CCDP on a group of participating families is defined as the difference between an observation taken after participation in the program and what would have been observed if the families had not been in the program. Since it is difficult to know how the participating families would have performed if they had not been part of the program, it is necessary to estimate what that performance would have been. Such an estimate is called a "no treatment expectation" and is generated best by measuring comparison group families that, through random assignment, are statistically comparable to the program families. Postprogram observations made on program families then are compared to the no-treatment expectation to yield the measure of program effect.

Further, the impact evaluation is examining mediating factors in order to explain variations in CCDP outcomes for different families and different projects. Data for the impact evaluation are being gathered through a variety of data collection methods, including the MIS, that include measures on the quantity and quality of program services received by families and a battery of outcome measures on program and comparison children, parents, and families (St. Pierre, Goodson, and Layzer, 1991). The latter chapters of this report provide a preliminary evaluation of program impact for families enrolled in CCDP from September 1990 through September 1992. This period covers 2 of the 5 years that families received services and includes an evaluation of the focus child at age 2.

DIFFERENCES IN SAMPLES BETWEEN THE FEASIBILITY ANALYSIS AND PROCESS EVALUATION AND THE IMPACT EVALUATION

The following is a discussion of the differences between the impact evaluation sample and the feasibility analysis and process evaluation sample.

Feasibility Analysis and Process Evaluation Sample

The sample used for the feasibility and process evaluation is composed entirely of program families because the design of the evaluation did not include a comparison group. The program families used in the feasibility and process evaluation include both originally assigned program families as well as replacement families randomly assigned to take the place of terminated program families. In some cases, program families included in the present analyses may have been substitutes for replacement families. In other words, if a program family is replaced and that replacement family subsequently is terminated, another replacement family is assigned in its place.

The sample used for the feasibility and process evaluations is composed of 3,300 program families and 14,486 individual family members enrolled on or before March 31, 1993. The 3,300 program families is substantially more than the number of program families in the impact evaluation (N = 2,214) because the feasibility analysis and process evaluation sample includes replacement families.

Of the 3,300 families, 1,197 (36 percent) attrited (this figure includes both family- and program-initiated terminations) as of March 31, 1993. The 2,103 program families that have not attrited are considered "currently enrolled."[4]

Impact Evaluation Sample

The sample of families used for the impact evaluation is composed primarily of the original program and comparison families and consequently differs from the sample used in the feasibility analysis and process evaluation. Unlike that sample, program families are included even if they terminated and had only been enrolled a few days or weeks or months. Replacement families were included in the impact evaluation only if they met the following criteria:

- Came from a project that had randomly assigned families to program, comparison, or replacement groups.
- Were randomly selected from the replacement group.
- Filled vacancies in the program or comparison groups that occurred because:
  - — The project had difficulty recruiting sufficient numbers of families to fill the three groups and was given permission by the ACYF to use its replacement pool families as "original program or comparison families";

---

[4] Note that although the sample size of enrolled families is stated here as 2,103, the sample size will vary somewhat in the presented analyses. This variation in sample size may be due to missing data or to use of a unit of analysis other than the family (i.e., the family member). Any departure from a sample size of 2,103 will be noted.

- The project lost families before the families were notified of their assignment; or

- Originally assigned families were determined to be ineligible at the time of enrollment because their income was too high or due to the aging out or death of the focus child.

The analyses presented in the impact evaluation draw upon data collected through interviews with parents and tests administered to children during 1992 and early 1993. Both types of data collection were conducted in the same session and scheduled to occur as close to each focus child's birthday as possible. Child and parent measures were "decoupled" in the analyses to allow the impact evaluator to age-link the child outcomes while permitting a comparison of families to reflect approximately the same length of tenure in CCDP. Therefore, the impact evaluation analyzes data collected when CCDP focus children were 2 years of age and when their parents had participated in CCDP for up to 2 years. A total of 2,214 program families and 2,197 comparison families comprise the impact evaluation sample.

OVERVIEW OF THE REMAINDER OF THE REPORT

The remainder of Part I (Chapter 2) provides descriptions of the characteristics of the CCDP families enrolled as of March 1993 and of the characteristics of the 21 CCDP projects included in this report.

Part II comprises the feasibility analysis and process evaluation findings. First, in Chapter 3 the conceptual framework and evaluation methods are discussed. The results are then presented for the analysis of projects' organizational lifecycles in Chapter 4. In Chapter 5 the results analyses are presented for the numbers of and reasons for terminations from CCDP (based on both MIS data and ethnographer reports). A summary of the ethnographers' analyses of family satisfaction with CCDP also is included in Chapter 5. In Chapter 6 the results are presented for the analysis of MIS data on family- and individual-level needs and goals, as well as of levels of service receipt and utilization and progress toward goal attainment. In Chapter 7 the results are presented for the qualitative data analyses of the impact of CCDP on various communities. The final chapter in Part II, Chapter 7, consists of an analysis of the Federal costs of CCDP.

Part III comprises the impact evaluation findings. First, in Chapter 9 the conceptual framework and study methods for the impact evaluation are presented. Then in Chapter 10, results are presented pertaining to parent and family outcomes, followed by the results of the child outcome analyses in Chapter 11.

The report summary and conclusion for both the feasibility analysis and the process and impact evaluations is presented in Part IV, Chapter 12.

The preliminary findings presented in this report reflect some of the progress that CCDP projects have made toward strengthening and empowering families in the relatively short time during which families have been engaged in the program. Therefore, these findings may underestimate the full impact that is expected to be realized after families receive the 5 years of required services.

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Chapter 2. CHARACTERISTICS OF CCDP FAMILIES AND PROJECTS

This chapter presents the characteristics of the program sample used in the feasibility analysis and process evaluation findings. The characteristics of the families and individual family members at recruitment are discussed first, followed by a detailed description of the characteristics of the 21 Comprehensive Child Development Program (CCDP) projects covered in this report.

CHARACTERISTICS OF PROGRAM FAMILIES

This section discusses recruitment eligibility, enrollment tenure, and sociodemographic characteristics of the feasibility analysis and process evaluation sample.

Recruitment Eligibility

In order to test program effectiveness most accurately, CCDP was established as a demonstration program incorporating an experimental design. Eligible families in each community were recruited and then assigned randomly to program, comparison, and replacement groups.

There were three eligibility criteria for all families initially recruited for CCDP. First, each family had to have an annual income below Federal poverty guidelines. Since all family members providing primary nurturance to the focus child are required to receive CCDP core services, the income of all these family members was entered into the formula used to determine a family's eligibility. Second, the family had to have an unborn child or a child under 1 year of age designated as the "focus" child for eligibility purposes at the time of recruitment (this is the child followed by the impact evaluation). Third, the family had to agree to participate in CCDP activities for 5 years.

It was expected that the families' socioeconomic characteristics at recruitment, such as income, would change over time as the families benefited from CCDP enrollment and moved toward self-sufficiency. Consistent with the intent of the CCDP legislation, a family is entitled to be enrolled in the program even when family income rises above the poverty line. Furthermore, families are not required to pay for services even when one or both parents are employed. This decision was based on the premise that employment and self-sufficiency are not necessarily equivalent and that requiring a fee for service when families are not self-sufficient would only, in many cases, serve as an economic disincentive for family members to continue working.[1]

During the recruitment phase, projects are expected to select families so that a proportionate representation of the demographic composition of their recruitment areas with respect to ethnicity and percentage of teen parents is reflected in every program. Recruited families are assigned randomly to program (treatment), comparison (control), and replacement groups. Urban projects are required to assign at least 120 families to each group, with rural projects assigning at least 45 families.

Enrollment Tenure

As families drop out of the program, their vacancies are filled by randomly selected replacement families. Consequently, as of March 31, 1993, CCDP families vary considerably with regard to the length of time they have received services. As seen in Exhibit 2-1 following this page, currently enrolled families have been with CCDP anywhere from 0 to 38 months, with the mean enrollment being approximately 25 months. More than 60 percent (n = 1,305) of the currently enrolled families have been in the program between 28 and 35 months.

On the other hand, as seen in Exhibit 2-2, the mean enrollment for terminated families is approximately 13 months. The length of tenure for approximately 50 percent of terminated families is less than 1 year.

A more complete analysis of attrition is presented in Part II, Chapter 5.

Sociodemographic Characteristics of the Program Families

Sociodemographic information, aggregated across the 21 CCDP projects included in this report, is presented on all CCDP program families (both currently enrolled and terminated) according to the ages of family members, residence in urban or rural areas, ethnicity, primary languages used, family composition, and family income at enrollment. Also presented is information about the primary caregivers' education, marital status, and services received 12 months prior to enrollment in CCDP.

Ages of Family Members

Exhibit 2-3 presents a breakdown of program family members by age: 44 percent are under age 5, 15 percent are ages 5 to 14, 9 percent are ages 15 to 19, 25 percent are ages 20 to 34, and 6 percent are age 35 or older.

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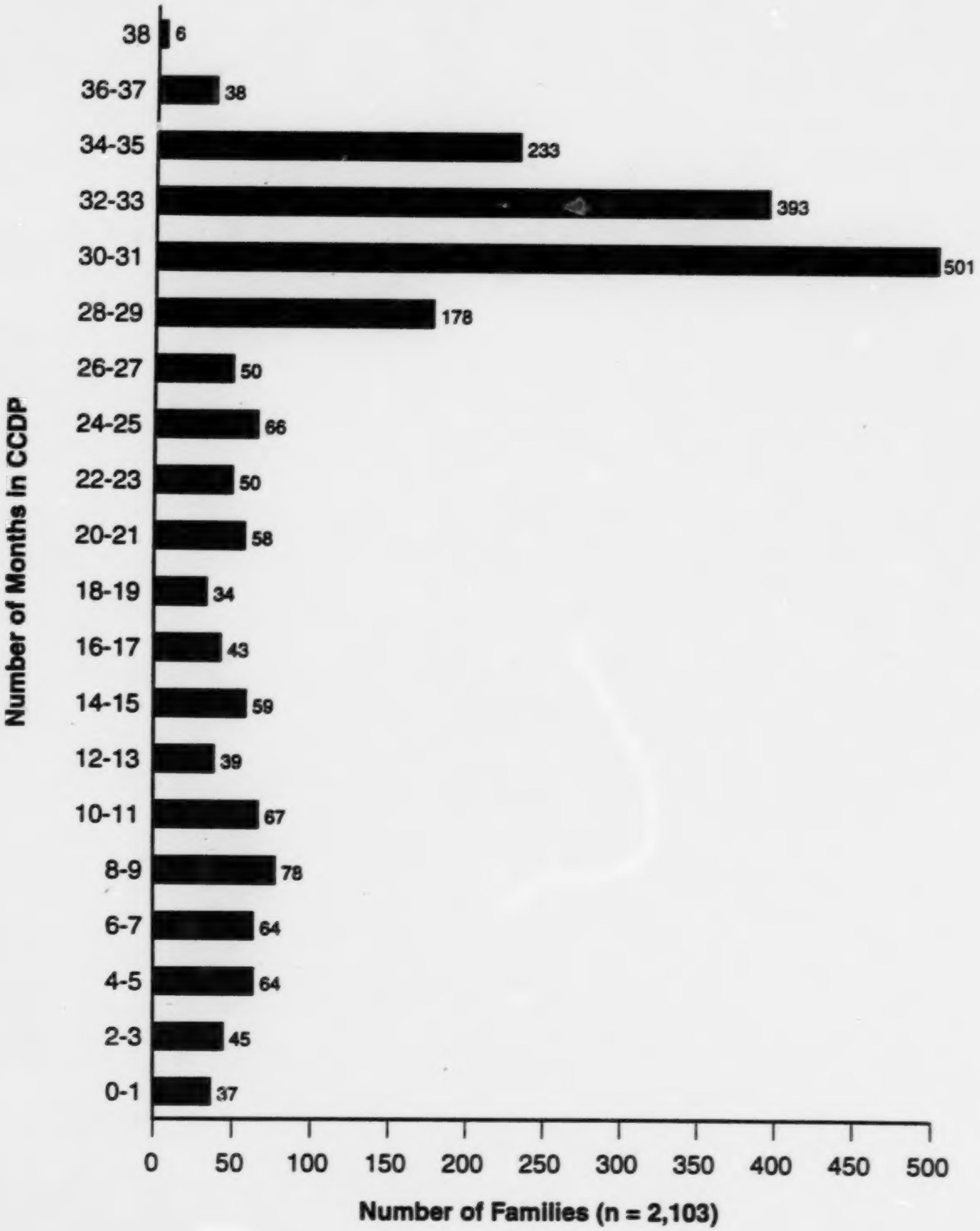
[1] The Administration on Children, Youth and Families currently is considering the use of a sliding fee payment plan based on family affordability.

Exhibit 2-1

Length of Tenure in Months for Currently Enrolled Families*



*Enrolled as of March 31, 1993
*Tenure rounded to nearest month

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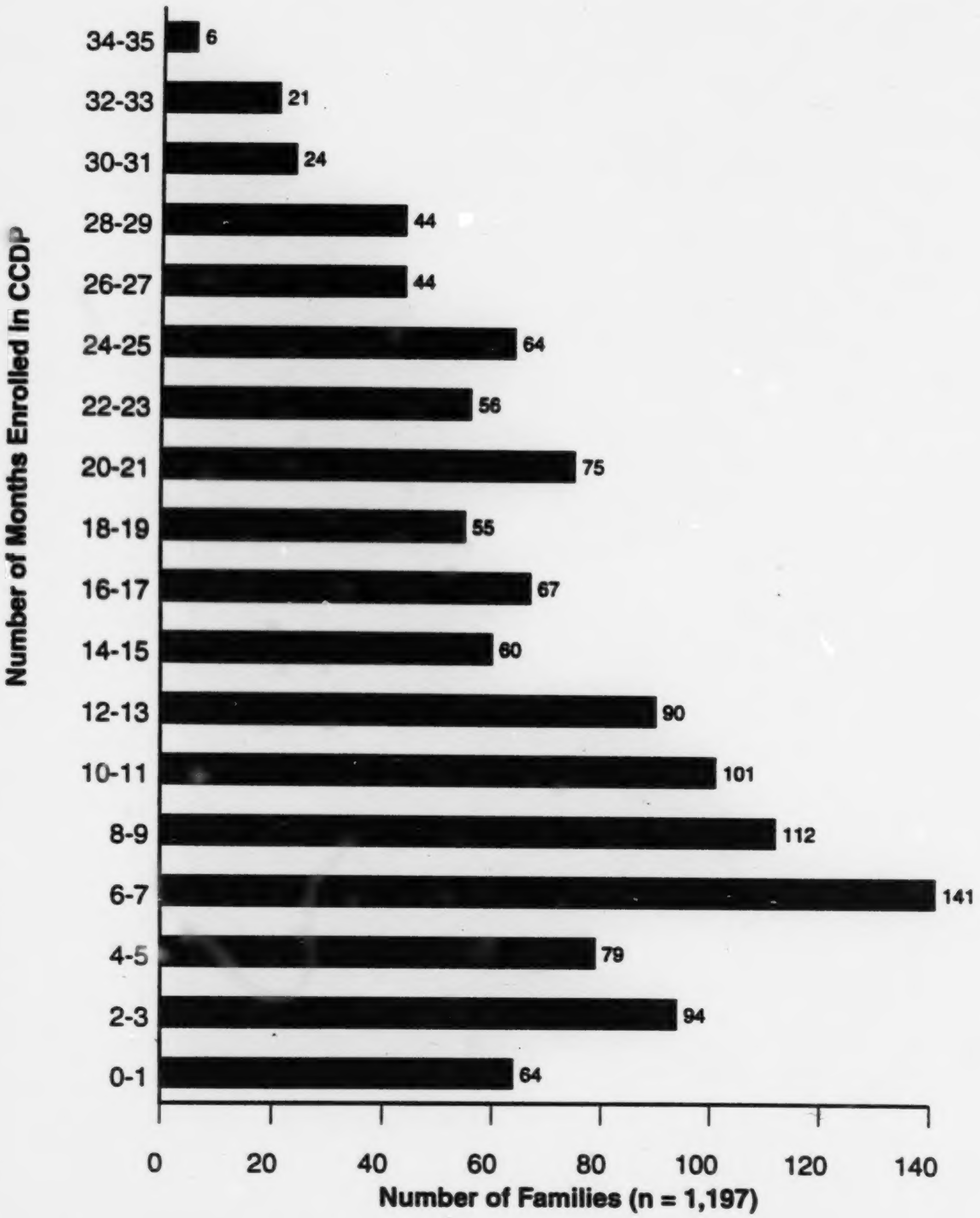
Exhibit 2-2

Length of Tenure in Months for Terminated Families*



*Terminated as of March 31, 1993
*Tenure rounded to nearest month

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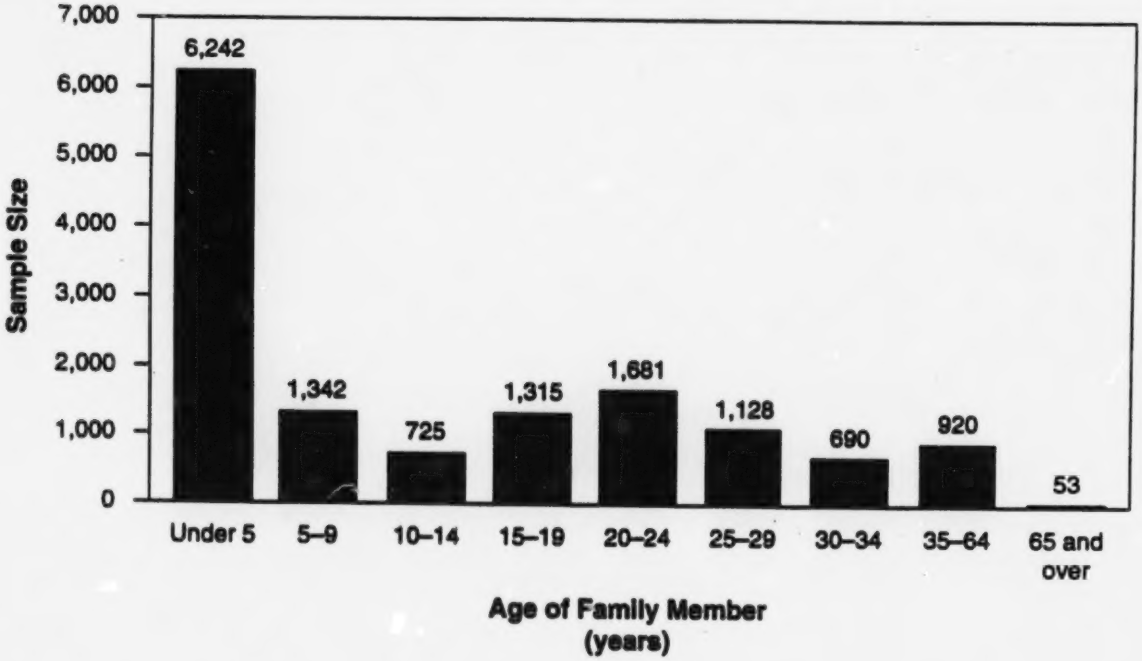
Exhibit 2-3

Age of Family Members*



*Data on the age of family members were missing for 390 individuals (n=14,096).

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Urban Versus Rural Locality

Exhibit 2-4 following the next page presents the percentages of families that live in urban or rural areas. The data indicate that 85 percent of the CCDP families reside in urban locations, whereas 15 percent live in rural areas. The same percentages were obtained for currently enrolled families.

Other data indicate that 77 percent of rural families have their own sources of transportation, compared to 39 percent of urban families. These findings have important implications regarding families' access to services, the extent to which CCDP projects must transport families in order for them to receive core services, and the costs associated with the provision of transportation.

Ethnicity of Families

During the recruitment phase, the ethnicity of families was classified according to the following categories: African-American, American Indian, Asian, Latino, white, and other. These categories were modified in December 1990, based on Office of Management and Budget (OMB) requirements. The revised categories, consistent with OMB requirements and utilized by all projects, are as follows:

- American Indian or Alaska Native;
- Asian or Pacific Islander;
- Black, not of Hispanic origin;
- Hispanic; and
- White, not of Hispanic origin.

As seen in Exhibit 2-5, the largest ethnic group for the combined sample of currently enrolled families and terminated families is black (45 percent), followed by Hispanic (27 percent), white (25 percent), American Indian (2 percent), and Asian (1 percent). The ethnicity of currently enrolled families is comparable: black (44.8 percent), Hispanic (27.8 percent), white (24.6 percent), and other (2.9 percent).

Twenty projects include a predominant ethnic family group (i.e., 60 percent or more of the families are of one ethnic category). For five programs, 90 percent or more of the families are of one ethnicity. Exhibit 2-6 shows that 10 projects have predominantly black populations, 5 projects have a predominantly Hispanic population, and 5 projects have predominantly white populations. Only one project did not have a predominant ethnic group.

Primary Languages Used

The primary languages used by CCDP families are classified according to the following OMB-approved categories of language:

- American Indian (e.g., Sioux and Cree);
- Asian (e.g., Korean and Vietnamese);
- English;
- Spanish; and
- Other.

As seen in Exhibit 2-7 following this page, English is the primary language of 84 percent of all families that have ever been enrolled in CCDP, followed by Spanish (14 percent), and other (i.e., American Indian, Asian, and other) (2 percent). The percentages for currently enrolled families are comparable (i.e., English, 82.9 percent; Spanish, 15.4 percent; Asian, 0.7 percent; American Indian, 0.5 percent; and other, 0.5 percent). At 19 projects, more than 50 percent of the families use English as their primary language. Only two projects reported more than 50 percent of the families using Spanish as their primary language (57.3 percent at Primero Los Ninõs in Las Cruces, New Mexico, and 67.3 percent at ENRICH in Venice, California).

Family Composition

The CCDP family includes all family members and other adults living in the home who provide primary nurturance to the focus child. As of March 1993, a total of 14,486 individuals and 3,300 families were enrolled in the 21 CCDP projects (an average of 4.4 individuals per family). Exhibit 2-8 describes the composition of CCDP families at recruitment in terms of the percentages of focus children, mothers, fathers, siblings, "other relatives" of focus children (e.g., grandparent or aunt/uncle), and nonrelatives.[2] The data indicate that focus children comprise 22 percent of individual family members of current and previous CCDP families, while the percentage for mothers is 23 percent; fathers, 9 percent; siblings of the focus child, 33 percent; grandparents, 4.6 percent; aunts/uncles, 5.3 percent; other relatives, 2.6 percent; and nonrelatives, 1 percent. The percentages among individuals currently enrolled in CCDP (N = 9,801) are similar. The percentage of focus children is 21.5 percent; mothers, 20.6 percent; fathers, 9.7 percent; siblings of the focus child, 33.6 percent; grandparents, 4.4 percent; aunts/uncles, 5.3 percent; other relatives, 2.7 percent; and nonrelatives, 1.1 percent.

These data underscore the fact that CCDP is a family support program serving many more family and related household members than just the mother and focus child. The other siblings and adults who are a part of the CCDP family receive a full range of CCDP core and noncore services designed to enhance their development and move them closer toward social and economic self-sufficiency.

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[2] The percentages for this analysis are based on 14,277 individuals because information about family composition was missing for 209 individuals.

Exhibit 2-4

Percentages of Families Living in Urban or Rural Areas

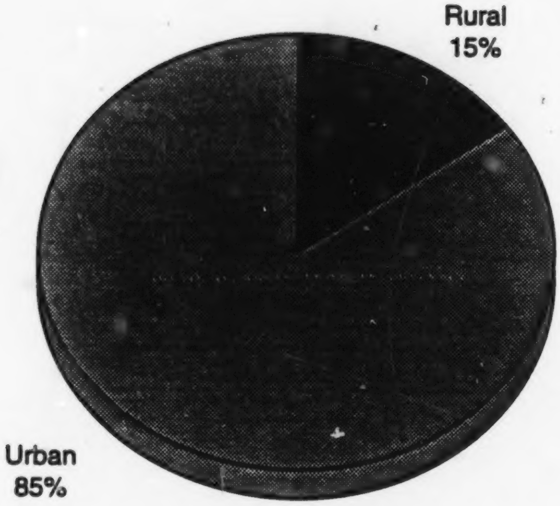
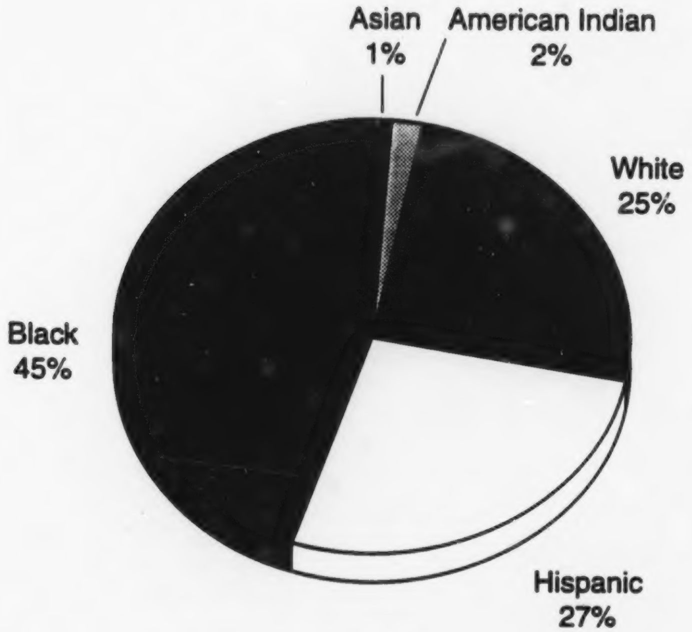


Exhibit 2-5

Ethnicity of CCDP Families



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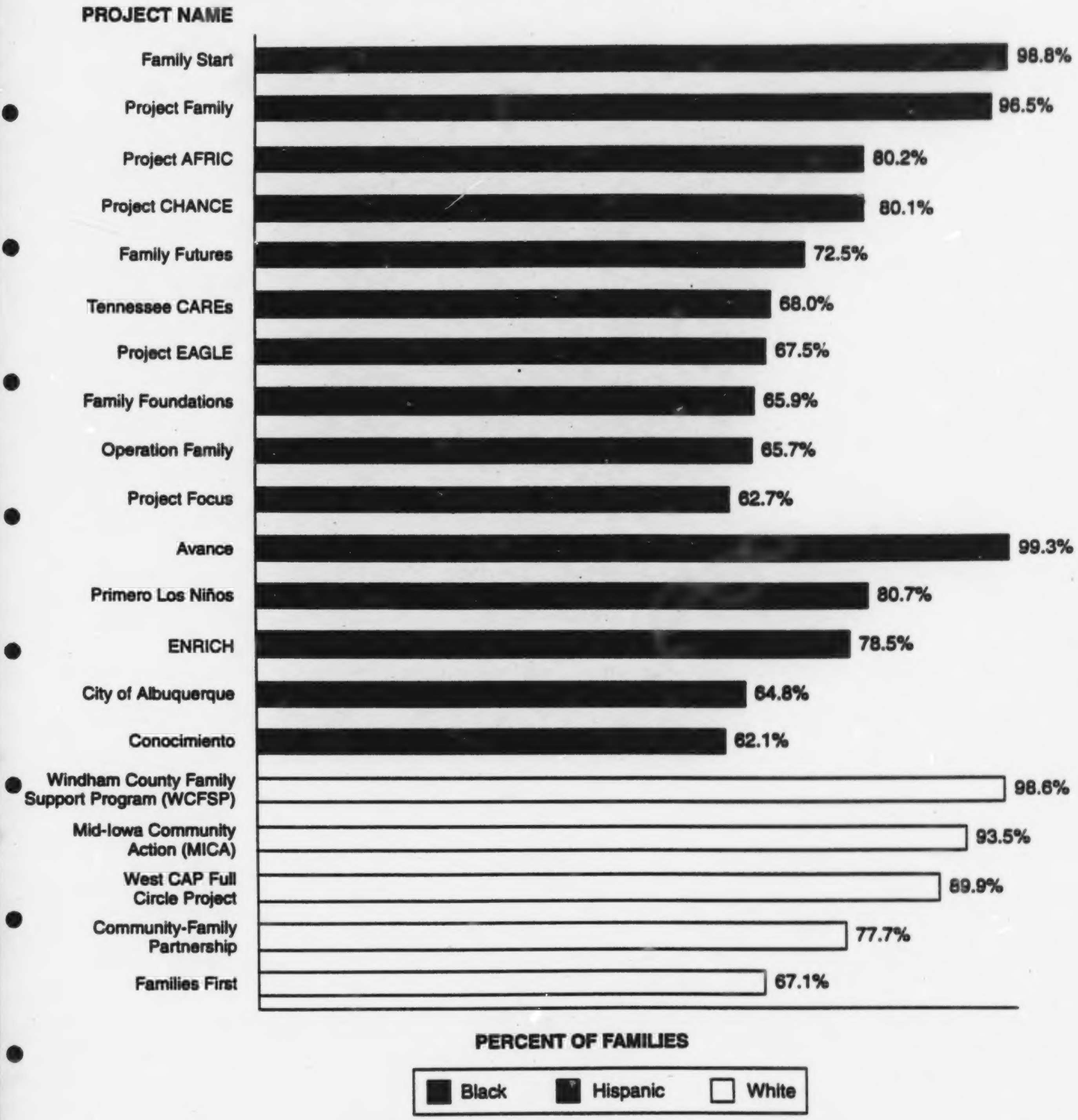
Predominant Ethnic Groups Across Projects[1,2]



[1] Projects were classified according to a predominant ethnic group if 60% or more of the families are of one ethnic category.

[2] Share Care project is not included here because there was no predominant ethnic group at this project.

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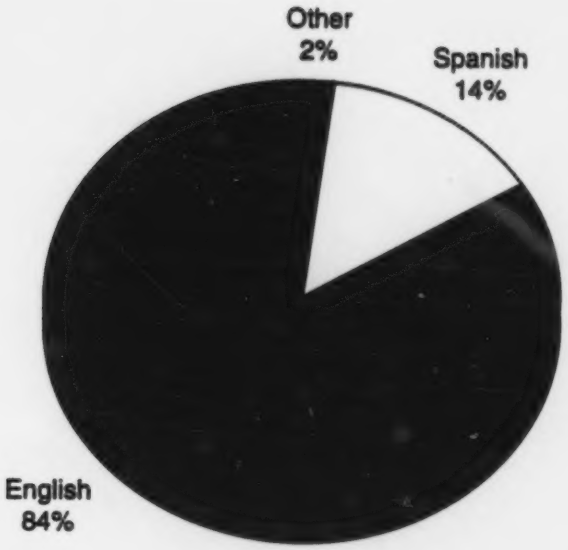
Exhibit 2-7

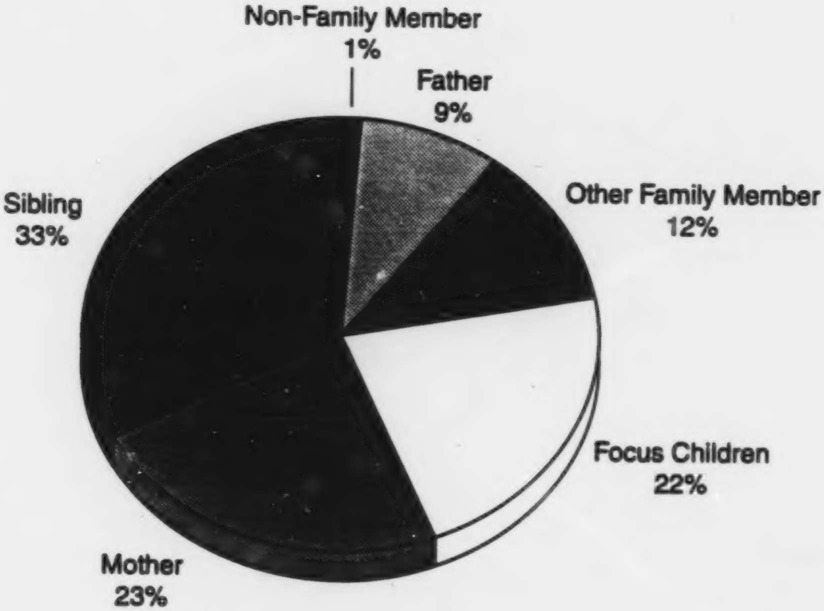
Primary Languages Used by CCDP Families



Other: American Indian, Asian, or other language.

Exhibit 2-8

Family Composition



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Family Income at Enrollment

Among 3,065 families from 21 CCDP sites recruited through March 1993, the average annual household income at the time of recruitment was $5,141 (income data were missing for 235 families). The majority of households (71.4 percent) had an annual income of $6,000 or less, 18.7 percent had an income of between $6,001 and $9,000, and 5.6 percent had an income of between $9,001 and $12,000. Only 4.3 percent of the households had an annual income above $12,000 (see Exhibit 2-9 following the next page).

Primary Caregivers' Education

At recruitment, the primary caregivers' mean number of years of schooling was 10.82.[3] As seen in Exhibit 2-10, 37 percent of the primary caregivers at recruitment had no educational degree or certificate, whereas 42 percent had high school diplomas; 10 percent had completed GED (general equivalency diploma) requirements; and 11 percent had received vocational certificates or associate's, bachelor's, or master's degrees.[4] The percentages for currently enrolled primary caregivers are similar to those for the combined sample (35 percent have no degree or certificate, 42 percent have high school diplomas, 11 percent have GED's, and 4 percent have vocational certificates or college degrees).

Primary Caregivers' Marital Status

Primary caregivers' marital status at recruitment is presented in Exhibit 2-11.[5] About two-thirds (62 percent) of the primary caregivers had never married, 27 percent were married, 11 percent were divorced or separated, and 1 percent were widowed. The percentages for currently enrolled primary caregivers were similar: 59.8 percent had never married, 28.8 percent were married, 10.8 percent were divorced or separated, and 0.7 percent were widowed.

Services Received by Primary Caregivers Prior to Enrollment in CCDP

The availability of baseline information on the services that families were receiving prior to enrollment in CCDP assists in understanding the types of families, defined by their needs, enrolled in CCDP. This information was collected by CCDP staff members during enrollment and recorded on the Family Profile in the management information system (MIS). There are some interesting findings evident from these data. First, 2,754 primary caregivers were receiving health screenings and 1,252 were receiving family planning at the time of enrollment. Only 250 were receiving vocational or technical training, and only 696 were in educational courses. One hundred and forty-five had received some drug or alcohol abuse treatment at the time of enrollment, and 101 had received employment referral services. Furthermore, 2,150 primary caregivers already were receiving nutritional counseling and education at the time of their families' enrollment in CCDP.

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[3] This mean is based on a sample of 3,064 caregivers because information about education level was missing for 236 primary caregivers.

[4] Unfortunately, 71 percent of the primary caregivers (n = 2,350) did not provide this information at recruitment; thus, the percentages are based on a sample size of 950.

[5] These percentages are based on a sample size of 3,236 because information about the marital status of 64 primary caretakers was not available at recruitment.

PROJECT CHARACTERISTICS

This section reports on the characteristics of the 21 projects discussed in this report—types and numbers of interagency agreements; advisory board characteristics; service delivery characteristics; services that CCDP projects are required to provide, refer, or broker; and noncore services provided, referred, or brokered.

Description of Sites

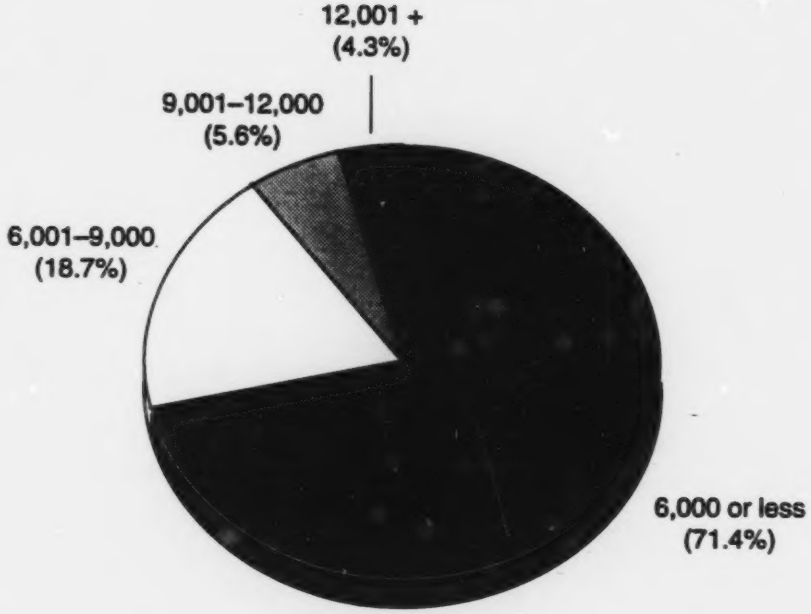
CCDP projects vary in the number of families served, the types of grantee agencies administering the projects, and the projects' locations and settings. These characteristics are summarized in Exhibit 2-12 on the following page. The legislation and the *Federal Register* announcement established some parameters within which the grantees designed their projects. Other aspects are unique to individual projects.

Urban projects are required to serve at least 120 families, and rural projects serve at least 45, but preferably 60, families. Five of the projects discussed in this report are categorized as rural. These projects are located in Marshalltown, Iowa; Nashville, Tennessee; Logan, Utah; Brattleboro, Vermont; and Glenwood City, Wisconsin. Of the 2 smallest rural projects, 1 serves 98 families and 1 serves 45 families. In addition, there are projects that are located in the city that serve only rural, outlying communities. The grantee in Nashville, Tennessee, is an example of such a project.

Sixteen projects are categorized as "urban." Of these 16 projects, 3 can be categorized as "superurban" (i.e., inner city). These superurban projects are located in Roxbury, Massachusetts; Baltimore, Maryland; and Brooklyn, New York. Some of the urban grantees, such as the College Station, Arkansas, grantee and the Las Cruces, New Mexico, grantee, serve both rural and urban locations. All urban sites, with the exception of 2, serve 120 families. One site, the City of Albuquerque CCDP project, serves 180 families and is operated by the City of Albuquerque Department of Human Services. Another site, the Parent-Child Resource Center, serves 160

Exhibit 2-9

Family Income



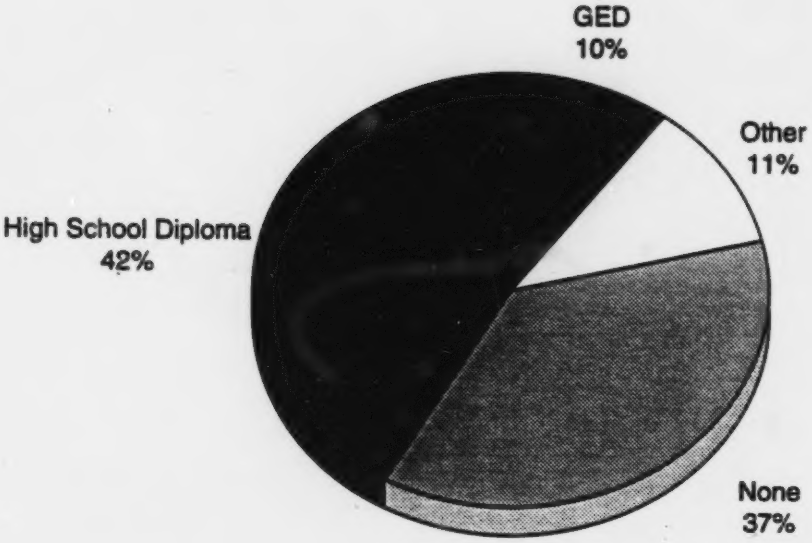
N=21

Mean Income = $5,141

n from 21 Sites = 3,065

Exhibit 2-10

Primary Caregivers' Educational Attainment



Other: Vocational certificates, AA, BA/BS, or Master's degree.

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Exhibit 2-11

Primary Caregivers' Marital Status

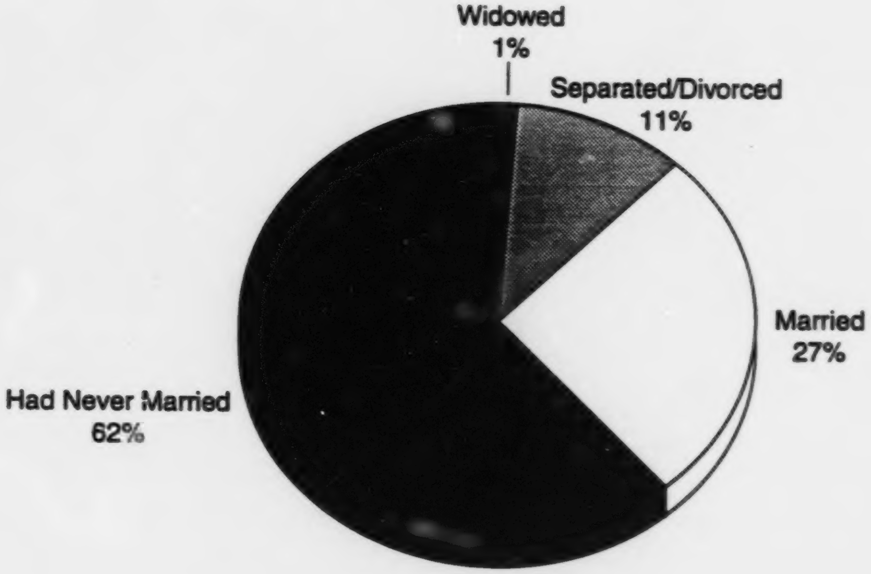

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Exhibit 2-12

Summary of Cohort 1 CCDP Grantee Characteristics[1]

GRANTEE NAMES

CHARACTERISTICS	Project AFRIC	Windham County Family Support	Project CHANCE	Family Start	Family Foundations	Operation Family	Tennessee CAREs	Project FOCUS	West CAP Full Circle Project	Project Family	Families in Partnership	Primero Los Niños	AVANCE	Share Care	Mid-Iowa Community Action	Project EAGLE	Family Futures	Community-Family Partnership	Conocimiento	ENRICH	Families First	Total
Basic Characteristics:																						
Type of Organization																						
Health Agency	●									●		●				●				●		5
School District		●																				1
Family Services Agency			●	●				●					●						●		●	6
Child Care Agency														●								1
Institute of Higher Education					●		●											●				3
Community Action Agency						●			●						●							3
City Administration											●											1
Foundation																	●					1
Geographical Area																						
Urban					●	●		●		●	●	●	●	●		●	●		●	●	●	13
Superurban (inner city)	●		●	●																		3
Rural		●					●		●						●			●				5
No. of Program Families																						
180											●											1
120	●		●	●	●	●		●		●		●	●	●		●	●		●	●	●	16
98															●							1
60							●		●									●				3
Project Location																						
Region I	●	●																				2
Region II			●																			1
Region III				●	●																	2
Region IV						●	●															2
Region V								●	●													2
Region VI										●	●	●	●	●								5
Region VII															●	●						2
Region VIII																	●	●				2
Region IX																			●	●		2
Region X																					●	1

*Also located in a rural environment.

[1] Includes only grantees included in the impact and process evaluations

families and is operated by the Edward C. Mazique Parent-Child Center, a nonprofit, community-based organization.

As discussed earlier, two of the urban sites (Project TIPP in Miami, Florida, and the Parent-Child Resource Center in Washington, D.C.) and one rural site (Little Hoop Community College in Fort Totten, North Dakota) are not included in the analyses conducted for this report.

CCDP projects discussed in this report are located in each of the 10 U.S. Department of Health and Human Services (DHHS) regions in the United States. Exhibit 2-13 following the next page provides a breakdown of CCDP projects by region. The geographic diversity of the project sites contributes to a wide variation in the cultural and ethnic composition of CCDP families, described in the previous section on family characteristics.

CCDP Projects' Organizational Structure

This section describes the organizational structure of CCDP projects in terms of program-agency fit and staffing patterns.

Program-Agency Fit

The kinds of agencies that have received CCDP grants vary. The grantee agencies that have administrative/fiscal responsibility for the grants include six family services agencies, six Head Start grantees, five health agencies, four institutes of higher education, four community action agencies, two child care agencies, one school district, one city administration, and one foundation (see Exhibit 2-12).

The type of grantee agency may differentially influence project development. First, the type of grantee agency can determine which services the CCDP project will provide itself and which services are provided through contractual or cooperative arrangements. For example, coordinating health services for CCDP families may not be an issue in program development for a grantee that is a major community health agency.

The type of agency also may affect staff recruitment and development requirements. A family services agency with a history of providing community outreach and case management services may have fewer staff development requirements or problems in implementing a case management function. In addition, an important factor in integrated service delivery is the stature and leadership role of the grantee agency in the community. It is, for example, reasonable to expect that the establishment of coordinated services for CCDP families with other agencies would be facilitated for a grantee agency that already has a major leadership position in community services.

Project administration is another of the determining factors for successful implementation of CCDP projects.[6] Similarly, the MIS is a critical component of CCDP and is a two-way system. In addition to recording information to send to Washington, D.C., it can be used as a tool to support the case management and counseling components as well as the whole program. In order to use the MIS to its full potential, the project director, data manager, and other staff need to have a thorough understanding of the MIS' capabilities. While projects generally hire a full-time data manager to oversee this aspect, all staff are involved in the implementation of the MIS, which enhances a project's smooth administration. In addition, every member of the CCDP staff is expected to become familiar with the MIS' codes and forms, as well as the available MIS reports. The data manager position is extremely important in CCDP projects. The skill level of the staff person needed for data management is much higher than what was thought originally by most projects. All other CCDP staff are involved in the MIS implementation in some way. Projects have found that involving other staff at various levels enhances smooth administration of the MIS.

Other administrative issues include factors such as the project's relationship with the grantee agency, the management structure and staff responsibilities, recruitment of CCDP families, planning for project facilities, establishment of interagency agreements, establishment of advisory boards and parent councils, and implementation of volunteer programs. For example, inadequate office space, too few staff to serve families effectively, or even the lack of experience of an agency in administering a large, complex Federal grant all directly relate to the feasibility of project implementation.

Staffing Patterns

Grantees have a variety of staffing configurations but share some common elements. Some projects use a team approach in which staff members with varied expertise serve a group of families. Most other projects use the generalist approach in which one staff member is responsible for direct services as well as for service coordination for each family. These approaches are described in detail in the section on case management.

Exhibit 2-14 following this page presents a typical project's organization. This type of organizational structure is functional and allows for a clear delineation of responsibilities among staff. This type of structure also increases accountability and integration across component areas.

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[6] Project administration was identified by CCDP project directors during a roundtable discussion at the ninth CCDP grantee conference, held in Annapolis, Maryland, in July 1992. The project directors met to extract from their experience those strategies that could facilitate the implementation of new projects. The goal of the roundtable discussions was to identify effective strategies to enrich new projects' understanding of options and steps that could be taken during the first stages of project implementation to improve services to children and families (see CSR, 1992).

Exhibit 2-13

Geographic Distribution of CCDP Sites

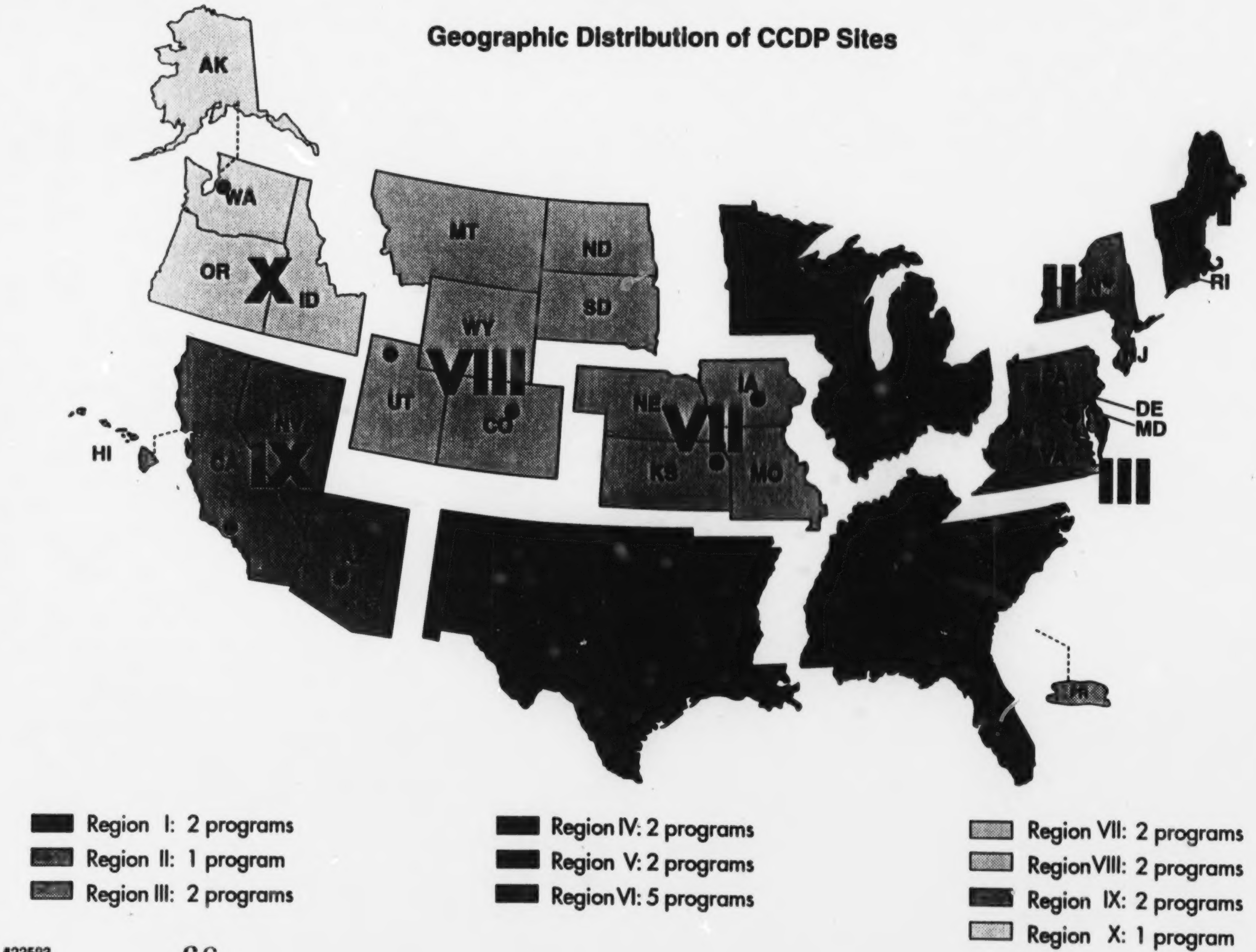
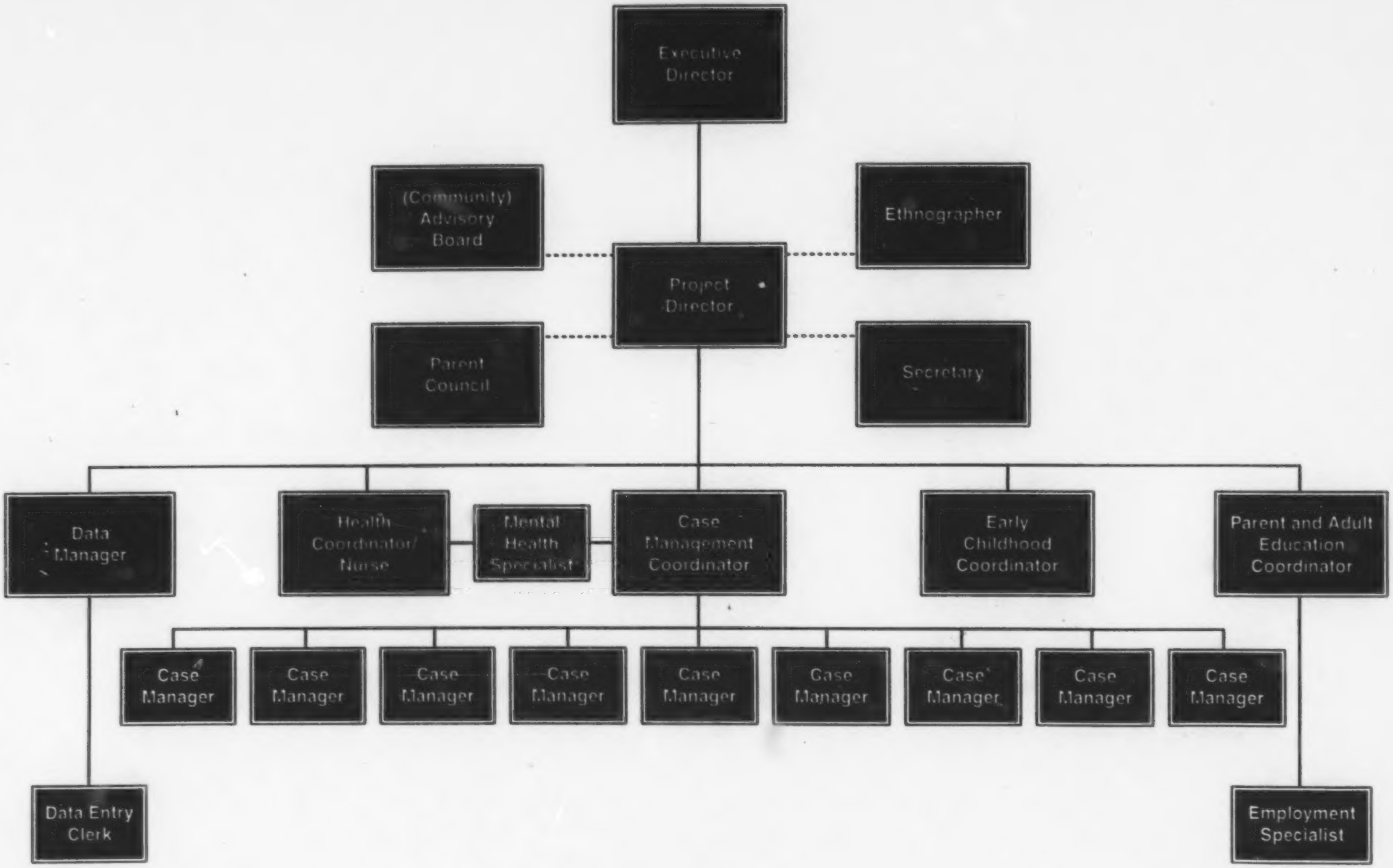

AK
WA
OR
X
ID
MT
ND
SD
WY
VIII
UT
CO
NE
IA
VII
KS
MO
NV
CA
IX
HI
II
RI
J
DE
MD
III
PR
Region I: 2 programs
Region II: 1 program
Region III: 2 programs
Region IV: 2 programs
Region V: 2 programs
Region VI: 5 programs
Region VII: 2 programs
Region VIII: 2 programs
Region IX: 2 programs
Region X: 1 program

Exhibit 2-14

Sample Organizational Chart for a CCDP Project


Executive Director
(Community) Advisory Board
Ethnographer
Project Director
Parent Council
Secretary
Data Manager
Health Coordinator/ Nurse
Mental Health Specialist
Case Management Coordinator
Early Childhood Coordinator
Parent and Adult Education Coordinator
Case Manager
Case Manager
Case Manager
Case Manager
Case Manager
Case Manager
Case Manager
Case Manager
Case Manager
Data Entry Clerk
Employment Specialist

Organizational structures vary across projects, but all have staff providing core services. Due to the comprehensive nature of CCDP, it is essential that staff be aware of one another's roles and responsibilities so they can work together to deliver, effectively, the needed services to families.

As indicated in Exhibit 2-15 following the next page, all CCDP projects have a project director, a data manager, an early childhood coordinator, an ethnographer, and case managers/home visitors. Eighty-six percent (n = 18) have a case management coordinator who supervises case managers, monitors and tracks home visits, and coordinates the case management function with the other project staff. All projects have staff members who carry a caseload of families. These staff members provide case management, early childhood education, and parenting education services to families in their homes.

All CCDP projects have an early childhood education coordinator who provides structure and supervision to those case managers, provides early childhood education to the families, and monitors the developmental screening and assessments administered to CCDP children. In some projects, the person in this position also is responsible for curriculum development and the development of individual educational plans. In addition to case managers who provide early childhood education to families in their homes, some projects have teachers (n = 13 projects) and teachers' aides (n = 9 projects) who provide in-center, early childhood education services to CCDP children.

All projects have a male involvement program to target CCDP fathers, but only 29 percent (n = 6) of the projects actually have a staff member designated as a male involvement coordinator. Similarly, all projects have a coordinating function to compile and track medical records for all families, including health assessments, prenatal visits, well-baby care, and immunization records. This function is carried out by a health coordinator in 14 of the projects and by nurses in 6 of the projects; 6 projects also have nutritionists on their health care teams. It should be noted that one project has its health coordinator function fulfilled through an interagency agreement with the local health department. In addition, 14 projects have a staff member who coordinates adult training and education.

Most projects (n = 16) have an employment specialist who develops linkages with the business community in order to place families in jobs and job training programs. Since projects recently have been encouraged to provide mental health support services directly, many projects (n = 17) now have a staff mental health specialist. This function provides general mental health support to families and referrals to appropriate agencies when necessary.

All projects also have an ethnographer who acts only as an observer and does not participate in the provision of services. The ethnographer provides three qualitative analysis reports per year to CSR, Incorporated, for use in the feasibility analysis and process evaluation. Each report contains ethnographic information on different topics that will be used in case studies and cross-site analyses.

As part of a commitment to recognize and respect cultural traditions and the values of the community, several projects initially employed individuals indigenous to the community to provide the case management services. Many of these individuals had less than a college education and often were referred to as "paraprofessionals." These staff members were considered valuable in serving as liaisons with other agencies as well as in acting as outreach workers to families in stress. Although extensive inservice training was provided, tensions soon resulted between the beliefs and practices of these staff members and the requirements of specialized training for dealing with multiproblem families. In many instances, programs had to revise their commitment to use paraprofessionals. This issue is discussed later in the case management section of this chapter.

CCDP staff characteristics vary widely across projects. Exhibit 2-16 following this page illustrates the varied characteristics (during CCDP's 3½ years of operation) of project staff (1) employed for 6 months or more and (2) who work 20 or more hours per week. The mean number of years of experience is 5.25, while the mean number of years of education is 15.3.

Interagency Agreements

Interagency cooperation/collaboration is discussed below in terms of formal and informal linkages, types of cooperating agencies, and purposes of linkages.

CCDP was conceptualized as a program to provide multiple, coordinated services to families in order to assist children in reaching their full potential and to enable parents to achieve economic and social self-sufficiency. Because grantees are not funded to provide all services directly, each CCDP project needs to make use of and coordinate with Federal, State, and local agencies to ensure that families are utilizing the range of services needed to attain their goals. Therefore, the integration and coordination of services provided to parents and to children is a critical component of CCDP.

In establishing such agreements and involving agencies with CCDP through written agreements, the hope is that the nature of the agencies' involvement will become more committed and invested. Through cooperative agreements, projects can facilitate the delivery of services to families through sharing resources. The presence of a formal interagency agreement implies that agencies will assume a more responsible role with regard to providing CCDP families with services both during the course of the project and (hopefully) after the project is completed.

Formal relationships with other agencies facilitate the coordination of services and help avoid duplication and gaps in services. Projects have developed written interagency contracts or agreements that delineate roles

Exhibit 2-15

Types of CCDP Staff Positions

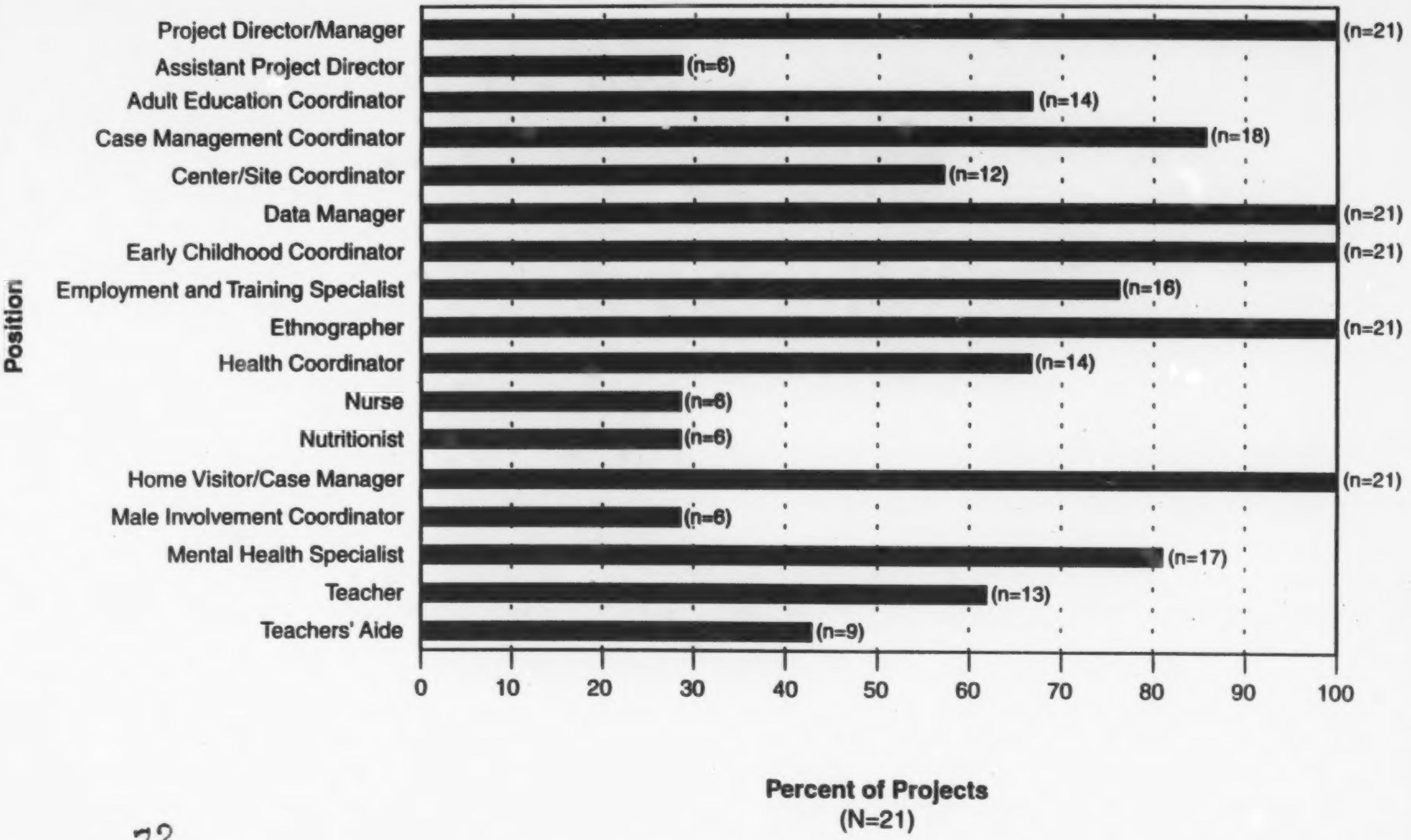
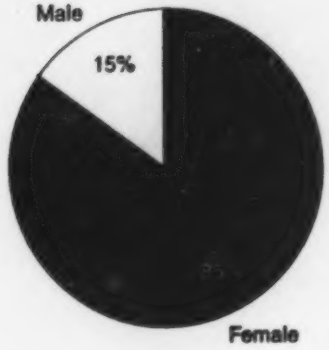
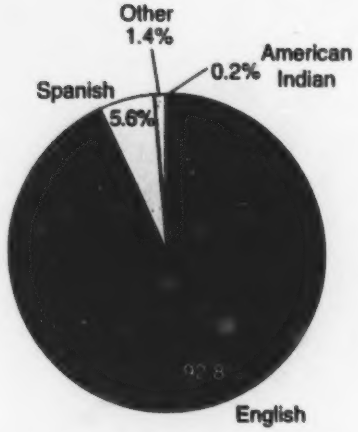


Exhibit 2-16

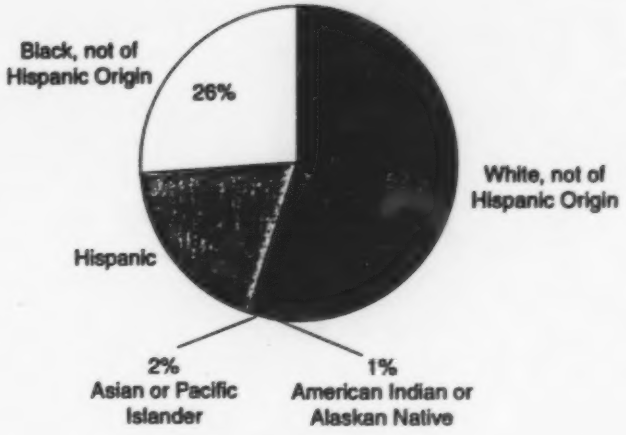
Characteristics of CCDP Staff Members



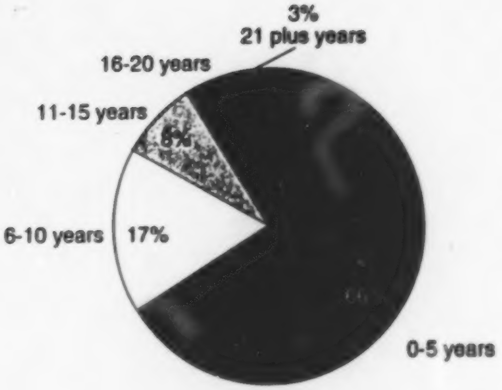
Sex



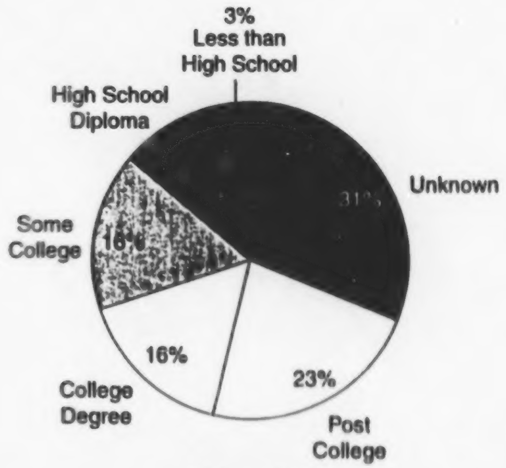
Primary Language



Ethnicity



Years of Experience



Education

and responsibilities, activities, and timeframes for each agency. These agreements are intended to clarify expectations up front but allow for change over time as roles evolve. The agreements aid in establishing common definitions, including the definition of the population to be served, and lead to a better understanding of what agencies can expect from one another. Agreements serve as a means to inform staff members about available services and how to access them. Effective interagency agreements greatly facilitate the linkage of families with service providers.

CCDP projects have implemented three different types of agreements in their efforts to coordinate service delivery to families. The three types of agreements are contractual, cooperative, and referral agreements, each of which is discussed below.

- *Contractual agreement.*—This agreement is formalized by a written document that outlines the provisions made by both parties. A contract specifies the services, including duration and type, to be provided to the program or to program families, includes a fee for services to be rendered; and is signed by an official of the agency providing services to the CCDP project. For example, many CCDP projects have contractual agreements for child care in which projects pay child care providers for a given number of child care slots.

- *Cooperative agreement.*—Projects also have developed cooperative agreements with both community and public agencies. A cooperative agreement is a formal, written interagency agreement that generally has been signed by both parties, usually senior staff members of the contributing agencies. The agreement (1) contains information about the services to be provided and the tasks to be performed by the agency and CCDP project and (2) specifies the duration for which the given tasks or services will be provided to families. Cooperative agreements are usually those for which no fees or expenses are incurred by the program for the receipt of services or support.

- *Referral agreement.*—A referral agreement is any kind of arrangement that allows a project to refer clients to a particular agency. This agreement generally is not written. Many of the projects with established referral arrangements have identified contact persons at the agencies in their communities to facilitate the process by which CCDP families receive services. Under a referral agreement, the contributing agency might specify that it will refer clients to the CCDP project for potential recruitment. The referral agreement indicates that the referring agencies support the CCDP project's goals and wish to contribute to its efforts. In some instances, the referral agreement specifies that cross-referrals (between CCDP and the agency) will take place.

All 21 CCDP projects have established interagency contracts or agreements with other community agencies. Agreements with community agencies are central to one of CCDP's major goals—the provision of comprehensive and integrated social and health services to families. These agreements ensure access to services by CCDP families. They promote services integration through case management not only for CCDP families but throughout the community. Through these agreements, projects may ensure quality and continuity of services and care and, in some cases, preferential treatment for CCDP families. Interagency agreements also may be used to provide a measure of assurance that essential data on services received by families are collected and are accessible to the CCDP project staff.

CCDP projects differ from one another in regard to which services are provided to families directly by the project and which services are provided by other community agencies. The nature of the grantee agency and the types of services available generally determine which services the projects are able to deliver directly and with which agencies projects need to enter into contractual or brokering/referral arrangements. For example, projects in which the grantee agencies are health centers, clinics, or hospitals usually are strong with regard to providing health care to families and would be less apt to enter into agreements with other agencies for delivery of health care services. The project directors suggested that projects consider doing the following when establishing interagency agreements:

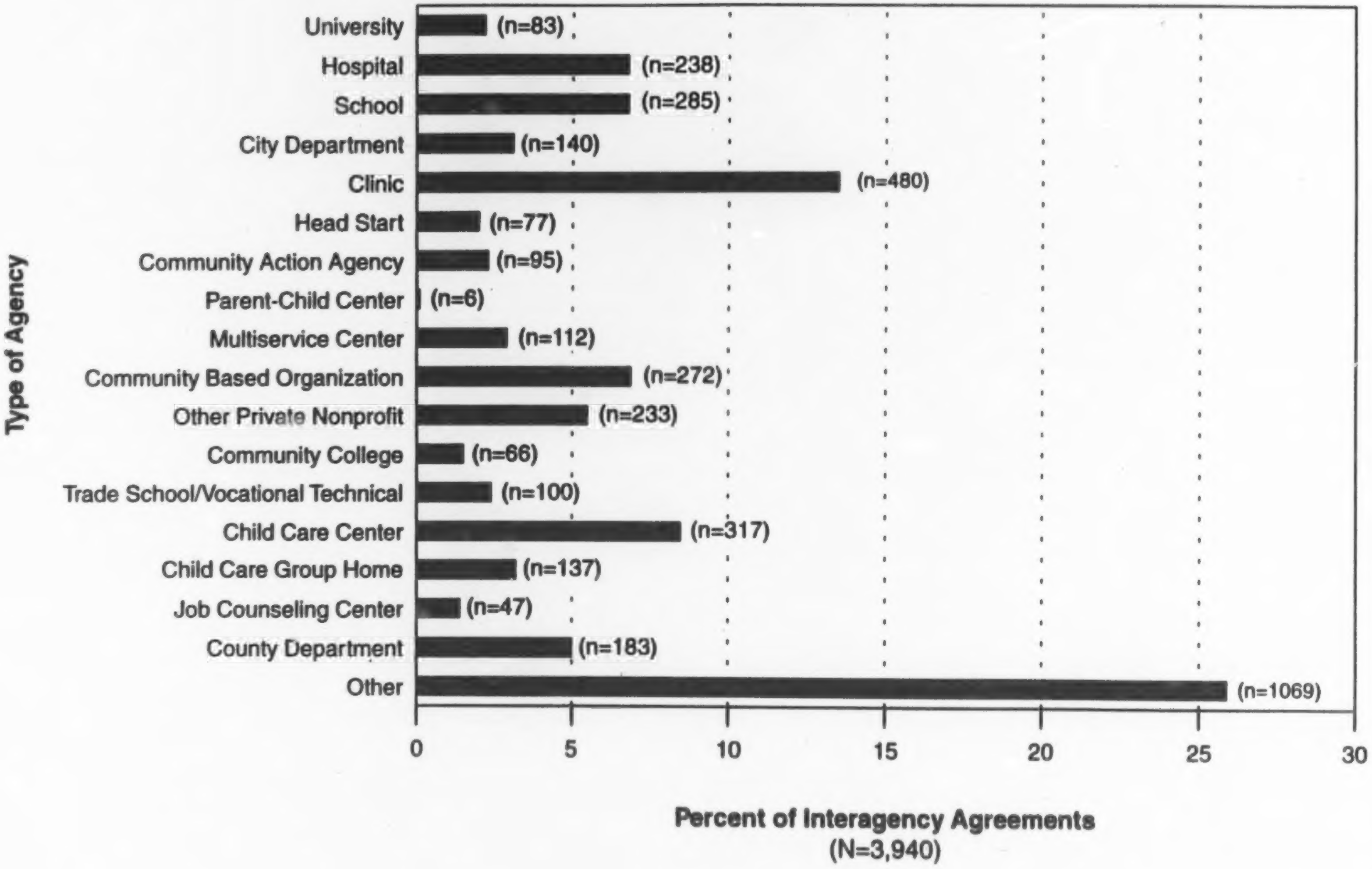
- Develop a format for interagency agreements that includes all information needed; and
- Provide coordinating agencies with very specific and detailed information about CCDP and its purpose as a demonstration program, and include information about what forms the agencies will be required to complete.

Exhibit 2-17 following this page indicates that 3,940 service providers have provided services to families in the 21 CCDP projects included in this report. The number of linkages classified as "other" (n = 806) is large because it includes numerous linkages with organizations such as churches, private physicians, private attorneys, youth organizations, and counseling services. Another reason for the large number of "other" linkages is that many of the linkages were utilized on a one-time basis, rather than the agency having established an ongoing contact, which is routine with an interagency agreement. Interagency agreements with clinics (n = 480), child care centers (n = 317), hospitals (n = 238), and schools (n = 285) are also significant to the operation of the CCDP projects.

After 3½ years of program operation, CCDP project directors have found that strong linkages with community agencies are vital to successful CCDP project implementation (CSR, 1992). Available data on the types of linkages (N = 1,220) between CCDP projects and service providers (including individuals and agencies) indicate that 26 percent (n = 315) involve contractual agreements, 23 percent (n = 283) involve formal cooperative agreements, and 51 percent (n = 622) represent informal referral

Exhibit 2-17

Service Provider Locations by Types of Agencies Across 21 CCDP Sites



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agreements. It should be noted that projects are moving toward increasing the number of written interagency agreements.

Advisory Boards

To encourage coordination with other community agencies, each CCDP project was legislatively mandated to establish an advisory panel comprising public and community service providers, service delivery agencies, business representatives, and CCDP families. Additional support was elicited through the formation of an advisory panel of key community leaders, who would be representative of the community and share their expertise in developing CCDP activities. In all sites, advisory board members include representatives of the key agencies providing services to the CCDP project. Exhibit 2-18 following the next page depicts the general composition of CCDP advisory boards.

Advisory boards have proved to be crucial to the development of the CCDP projects. During the startup phase, the advisory boards connected the projects with public, private, and community resources that could be used for recruiting families, providing services, and resolving family crises. Currently advisory boards provide contacts for job training, apprenticeships, internships, and employment as families move out of crisis toward self-sufficiency. Several boards are central to project efforts to become institutionalized within the community.

As with most program activities, the role and involvement of the advisory boards have evolved and solidified since CCDP's inception, to where they have become an increasingly valuable resource for the grantees. Many have developed subcommittees comprising members who are more "mission driven." Fourteen of the 21 projects have fully functioning subcommittees. These subcommittees focus on specific tasks and issues and report to the overall board.

Throughout the life of a CCDP project, advisory boards can organize, volunteer, and support mentor programs as well as seek in-kind contributions. They can become the public relations arm of the CCDP projects. Advisory boards provide projects with individually named contacts who often can expedite matters within large community agencies and organizations.

The average number of parents on an advisory board is five. Parent members of advisory boards help to keep other members focused on family issues and are a constant reminder to the board of the realities of life on a low income.

A CASE MANAGEMENT MODEL

Within the CCDP model, the use of family focused case management is a key aspect of service delivery. Case managers are responsible for building relationships with families and for providing, brokering, coordinating, and monitoring the delivery of services that are necessary to achieve a set of goals established by the family. The case manager's job is highly complex, requiring, at a minimum, the following: (1) case management skills, (2) knowledge specific to poverty populations being served, (3) knowledge about regulations of categorical assistance programs, (4) knowledge about accessing community resources, (5) interpersonal skills, and (6) counseling skills.

Characteristics of CCDP Case Management

Most of the case management approaches and methods used by the grantees are strategies based on the family support/family education model (Weiss and Jacobs, 1988). This model is based on several assumptions including the following: (1) services provided to families are determined by the needs and goals of the parents and are responsive to the cultural and social characteristics of the communities in which the families live; (2) services provided should build on the strengths that whole families and individual family members already have; and (3) services should increase the family's ability to cope rather than provide a system on which families become dependent. Most of the approaches and methods emphasize the concept of family empowerment—that is, family members are expected to be active rather than passive participants and to assume decisionmaking power in terms of making choices and defining the services desired.

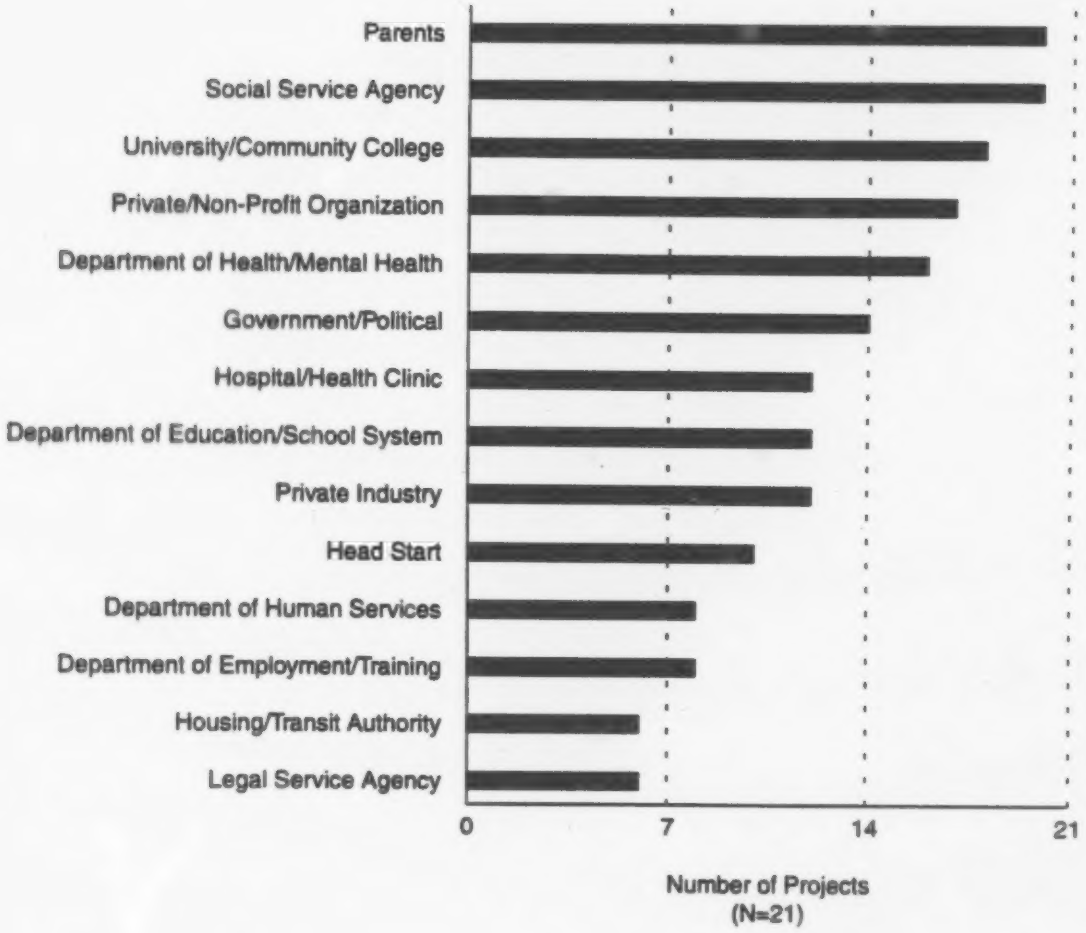
The case management approaches and methods used by a CCDP project largely determine the backgrounds and qualifications of the case manager(s) employed by the grantee. As discussed earlier, several projects initially used only individuals indigenous to the community served. These individuals had limited college educations and related experiences in working with families. The criteria used for the selection of paraprofessional case managers during the first service year (Year 2 of CCDP) are the following (CSR, 1991):

- Have life experiences that mirror those of the target families;
- Have experience as a teen parent or single parent; and
- Be indigenous to the community.

After the first service year, the CCDP project directors found that the chances of success were enhanced if a combination of professional and paraprofessional staff provided case management services. Hiring practices for case management staff evolved to include the following qualifications (CSR, 1992):

Exhibit 2-18

Composition of Advisory Boards



Sources: Survey on Service Delivery and Project Advisory Board Statements.

- The ability to develop caring relationships and an interest in continuing to learn;
- An interest in moving families out of the welfare system (as opposed to "working the welfare system");
- Experience working with families in poverty and domestic violence situations;
- Knowledge about empowerment issues and a strength-based approach;
- A "family" orientation and the ability to work with the entire family;
- The ability to view problems as a challenge;
- A background in working with chemical dependency; and
- Cultural sensitivity—the ability not to use personal values to judge a family's situation.

Structured Models of CCDP Case Management

There are two types of case management structural models used in CCDP: the case management generalist model and the case management team model. These models and the caseload sizes are discussed below.

Case Management Generalist Model

Sixteen programs use the generalist model of case management. In this model, the case manager assumes all the case management functions and provides the CCDP core services (e.g., early childhood education, parenting training, and case management) during home visits.

The advantages of a generalist model are as follows: (1) each family has one person to work with, (2) case manager work is less likely to be routine because several functions are performed, (3) one case manager is responsible for each family, (4) coordination with early childhood staff is not an issue, and (5) this model is less expensive than the team model. The disadvantages are that staff must have skills in diverse areas because of the comprehensiveness of the services mandated by CCDP.

Case Management Team Model

In the five projects (i.e., Operation Family, Project Family, Family Foundations, Families First, and Tennessee CAREs) that use the team model of case management, each staff member is responsible for providing services in his/her area of expertise. Collaborative teams are involved in service planning and decisionmaking, and each team member provides a service as part of an agreed-upon plan. Usually one of the staff members maintains primary responsibility for coordination of the plan.

The advantages of this case management model are as follows: (1) a team can provide high-quality services through individual staff expertise, mutual planning, and problemsolving; (2) teams can become a support system for the staff; and (3) sharing responsibility for difficult cases reduces staff burnout.

One disadvantage of this model is that lines of responsibility can become blurred, services may be duplicated, and accountability for service effectiveness may be eroded. Another potential problem is that clients must negotiate with a variety of people about their services. This may present additional difficulties, especially for families with multiple problems. To prevent these difficulties, team members receive training and continuously revise their collaborative planning, coordinating, and evaluative roles. For this model to be effective, team members need to develop clear lines of communication and reporting among themselves in addition to receiving training.

One project uses a specialist structure for case management in which staff members work together as a team, with each member providing a specialized component of the total service delivery plan (e.g., substance abuse, health, and assistance with income support). Within this structure no one person has overall case management responsibilities for a given family; instead, the responsibilities are shared by many staff members.

Caseload Size

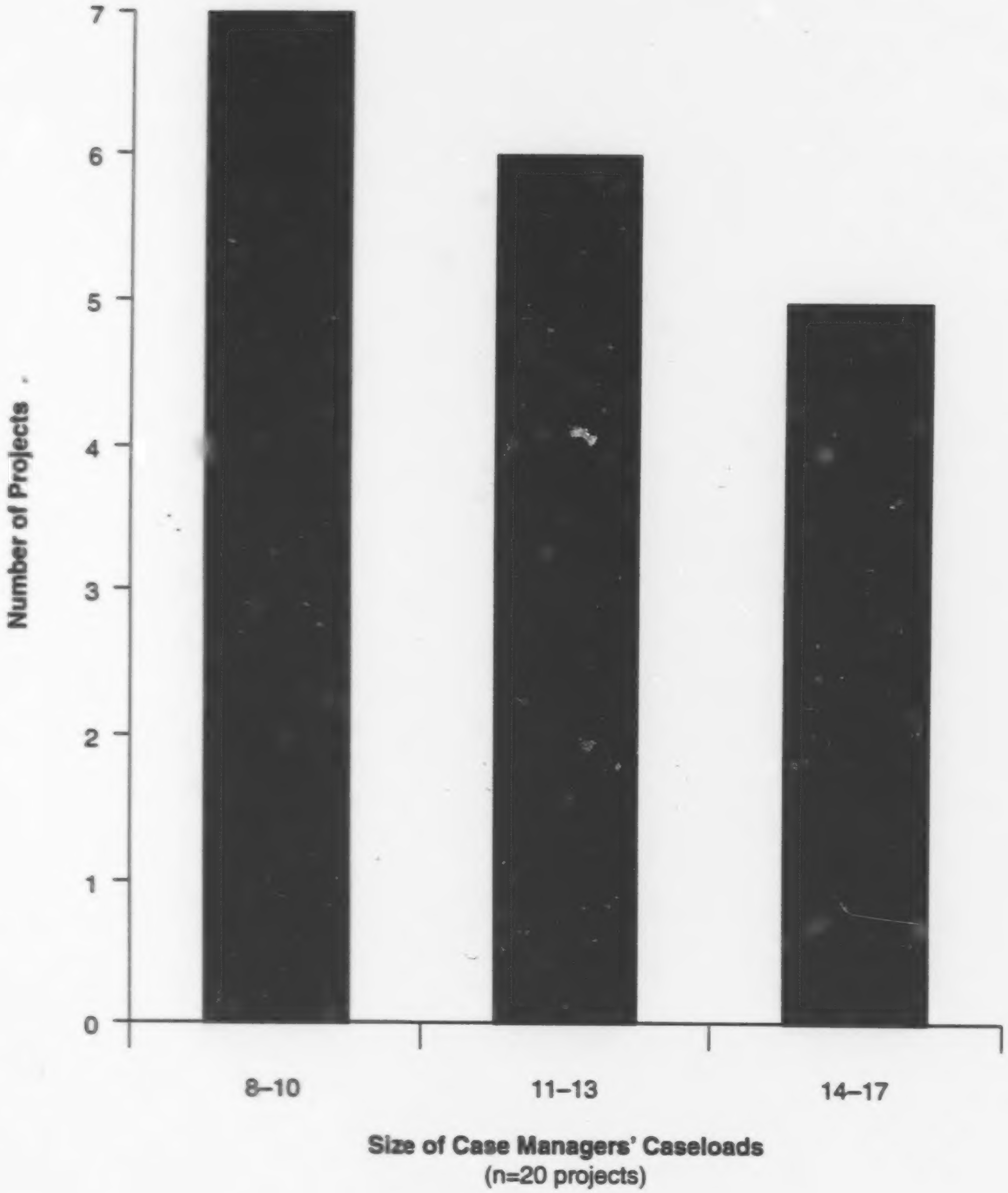
Among the 11 generalist model projects visited during the startup phase, the number of families assigned to each case manager ranged from 8 to 30, with an average caseload of 16. Most case managers had between 13 and 21 cases, with 19 to 21 being the most common range. During the third year, for the 18 CCDP projects that used a combined case management/early childhood education model, 7 had caseloads of 8 to 10 families, 6 had caseloads of 11 to 13, and 5 had caseloads of 14 to 17, with an average caseload of 13 (see Exhibit 2-19 following this page). The 3 projects that utilized a case management team model had average caseloads of 12, 14, and 20.

Activities of the Case Manager

This section describes activities of the case manager, including home visits, family needs assessments, family service plans, and crisis intervention.

Exhibit 2-19

Case Managers' Caseload Sizes



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Home Visits

More than three-quarters of the projects reported that staff members made home visits at least once every 1 or 2 weeks. MIS data indicated the following:

- For CCDP projects that use a combined case management/early childhood education model (in which one staff member provides all these interventions), 75 percent of the CCDP Home Visiting Program Description Forms indicated that home visits were conducted four times per month, 10 percent of the home visits were conducted three times per month, and the remaining 15 percent were conducted at least two times per month. The mean length of the home visits was 70 minutes, with 48 percent of the visits lasting 75 to 90 minutes, and 52 percent of the visits lasting between 30 and 60 minutes.
- For the CCDP projects that administer programs in which separate home visitors provide case management and early childhood education interventions, case management visits are conducted at least two times per month in 58 percent of the programs and three to four times per month in 42 percent of the programs; the average length of these visits is 65 minutes.

Family Needs Assessments

Conducting a family needs assessment is one of the essential tasks of the case manager. The quality and extent of information gathered in this assessment determines many of the activities that follow the assessment.

All CCDP projects use some type of family needs assessment. The simplest use the MIS Family Assessment Form as a guideline. However, most projects use additional assessment forms, including their own, standardized instruments/scales, or a combination of both. For example, one project uses the Family Strengths and Needs Assessment, which addresses child, adult, and family domains and includes guidelines for 13 key areas, such as family coping strengths, family relationships, and family support networks. Another project uses a combination of its own Family Resource Assessment and the following tools: Home Observation of the Environment (B. Caldwell), Difficult Life Circumstances (K. Barnard), Community Life Skills Scale (K. Barnard), and the Teaching and Feeding Scales (University of Washington School of Nursing). Some projects use their own forms in combination with instruments developed by Carl Dunst and his colleagues, such as the Family Needs Scale, Support Functions Scale, Resource Scale for Teenage Mothers, Family Resource Scale, and Inventory of Social Support.

Because the CCDP projects are multidisciplinary in nature, additional family needs assessments in specific areas such as health/nutrition, employment/training, and early childhood education are often a part of the assessment process; these may be done by the case manager or, more often, by specialists. In fact, some projects allow for the comprehensive nature of the assessment process by conducting a general assessment first, as the case manager works to stabilize the family's situation, and then a more comprehensive assessment after the results of the specialized health, employment, and early childhood assessments are received. Assessments are updated periodically.

Family Service Plans

Because goal attainment is a key outcome variable, determining needs, developing a family service plan, and documenting goals are basic to CCDP projects. The family service plan is based on the family needs assessment. The plan is developed by the case manager and family and usually includes the following types of information: resources needed, prioritization of goals, actions to be taken, roles family members will play, timeframes, degree of client involvement, and evaluation of the extent to which needs have been met.

All CCDP projects utilize a family service plan. The development and review of this plan are critical for three reasons: (1) the plan provides an organizing structure; (2) the plan separates goals into discrete attainable steps; and (3) the plan assigns family members, the case manager, and other staff members responsibility for specific actions.

Most projects have a specific form(s) to document family plan information (see Appendix A for an example). One project uses the following three forms: (1) Goals: Short- and Long-Term, (2) Goal and Action Plan, and (3) Quarterly Review of Progress and Efforts Toward Goals. This project also has organized information on adult needs and goals around the CCDP core areas. Another project uses an Individual Action Plan for family members as well as a Family Action Plan.

Because specific goals and the activities required to attain these goals are constantly changing, it is critical to review and update each family's progress and goals periodically. Thirty-eight percent of the projects specified a timeframe for the completion of the family service plan, ranging from 1 month to 90 days.

Crisis Intervention

The CCDP legislation specified that families be provided with assistance to secure adequate income support, health care, nutritional assistance, and housing. For projects located in urban areas, the housing crisis caused case managers to spend much of their time trying to locate housing for families. Throughout the first full service year (Year 2), case managers spent much of their time moving families out of crisis toward empowerment-oriented activities. A delicate balance exists between addressing crisis and long-term needs and setting individual and family empowerment goals. Many project staff felt that it is important for families not to be forced to set goals before they are ready, but it also is important for the case manager not to allow crisis situations to cause lengthy delays in setting these goals.

DISCUSSION OF CCDP CORE SERVICES

This section describes the legislatively mandated core services made available for CCDP children (i.e., infants, toddlers, and preschoolers) and core services for parents and other household family members. A discussion of noncore services follows. As discussed in Chapter 1, these core services are embodied in the Comprehensive Child Development Act of 1988.

Core Services for Children (Infants, Toddlers, and Preschoolers)

This section discusses the availability of services in the areas of early childhood education/early intervention, child care, and health care and nutritional services.

Early Childhood Education/Early Intervention

Criteria for the provision of early childhood education and/or early intervention are as follows:

- Developmental screenings and assessments must be completed by the project or another agency for all children under compulsory school age in the program family.
- An individual development plan must be written for all children under school age in the family. This plan must be based on the findings of the screening and assessments.
- Children who are at risk or developmentally delayed must have timely access to an intervention program.
- Each project must identify an appropriate developmental curriculum or curricula and adequately train staff members to implement the curriculum.
- An adequately intensive child development experience must be provided for all children under school age. If the parent is directly involved in the early childhood education activities for the child in a home or a center (i.e., if the early childhood experiences are parent focused), then the activities must be provided at least once per week. (It is assumed that if parents are involved in providing the early childhood experiences, the activities will be repeated during the rest of the week.) If the parent is

> not directly involved (i.e., if the child is in a center or full-time care and/or the teacher is providing the early childhood experiences), then the activities must be provided at least three times per week.

As discussed in Chapter 1, all CCDP children under school age must have a developmental screening and assessment and any needed early intervention service. Developmental screening is a process used to identify children with or at risk of having delays in the development of language, cognition, motor, and social and emotional skills. Instruments used for developmental screening are standardized and norm referenced. That is, each instrument has been administered to a large sample of children that is representative of the population on which the instrument is to be used. Scores obtained from the screenings are utilized to develop the standards or the norms for that particular instrument. Screening instruments are intended to be a quick mechanism for obtaining a characterization of each child's developmental status; therefore, a more complete diagnostic evaluation must be conducted to determine if the child who exhibits a developmental delay on a screening test has a handicapping condition or requires specialized services.

MIS data indicate that of 9,023 CCDP children, 35 percent have been screened using the Denver Developmental Screening Test (DDST-I), 12 percent with the DDST-II, 11 percent with the Battelle Development Inventory (BDI), 8 percent with the Brigance Diagnostic Inventory of Early Development, 5 percent with the Receptive-Expressive Emergent Language Scale, and the remaining 29 percent with a variety of other recommended screening tools (see Exhibit 2-20 following this page).

Developmental assessments involve the process of gathering specific information on each child's mastery of skills in order to plan for appropriate educational activities for that child. The instruments used for an educational developmental assessment are behavioral measures that focus on specific skills in areas such as receptive and expressive language, gross and fine motor skills, cognitive, self-help, socialization, readiness for reading and math, and other adaptive skills. Unlike screening instruments, developmental assessment instruments are often criterion or path referenced. That is, results provide information that is useful in planning educational interventions. To select activities that are developmentally and functionally appropriate for an individual child, the early childhood educators and the child's parents combine the results of the developmental assessment, observations and knowledge of the child, and the child's learning style and past developmental pattern. A developmental assessment specifies which skills the child can and cannot perform, identifies the skills that are emerging, and helps determine which skills the child should be working on. The assessment also serves as a guide to track the child's performance over time.

Aggregate MIS data indicate that 18 percent of the projects use the Hawaii Early Learning Profile Instrument, making it the tool most frequently used by the CCDP projects when conducting developmental assessments.

Exhibit 2-20

Screening and Assessment Instruments and Curricula

Screening and Assessment Tools	No. of Projects	Curricula	No. of Projects
Denver Developmental Screening Test II	12	Hawaii Early Learning Curriculum	12
Hawaii Early Learning Profile Instrument	1	Young Children in Action (High/Scope)	4
Learning Accomplishment Profile	3	Small Wonder	7
Early Learning Accomplishment Profile	1	Good Beginnings	1
Learning Accomplishment Profile - Diagnostic	1	Partners for Learning	1
Battelle Development Inventory	6	Portage	3
Brigance Diagnostic Inventory of Early Development	3	Parents as Teachers	2
Receptive-Expressive Emergent Language Scale	2	First Step	1
Bayley Scales of Infant Development	1	Infants and Toddlers Curriculum and Teaching	1
Transdisciplinary Play-Based Assessment	1	On-Base	1
Infant Monitoring Questionnaire and Early Screening Inventory	1	Zero to Three	1
Portage	2	Developmentally Appropriate Practice	1
Developmental Profiles Checklist	1	Anti-Bias Curriculum	1
Measures Battery	1	The Creative Curriculum for Early Childhood	1
Partners for Learning	1	Brigance	2
Initial Child Assessment	1	Learning Accomplishment Profile	3
Humanics	1	Little People's Workshop	1
Vineland	1	Warm World	1
Child Observation Record	1	Learning Accomplishment Profile—Diagnostic	1

Exhibit 2-20 *(continued)*

Screening and Assessment Tools	No. of Projects	Curricula	No. of Projects
High/Scope	1	HOME	1
Local CCDP project developed	2	Black Parenting Curriculum	1
		Adolescents as Parents Curriculum	1
		Nurturing Curriculum (Parents Anonymous)	1
		Local CCDP project developed	3

Fourteen percent use the Brigance Diagnostic Inventory for Early Development, 10 percent use the BDI, 9 percent use the DDST-I, 8 percent use the DDST-II, 6 percent use the Learning Accomplishment Profile, and the remaining 35 percent utilize other recommended assessment tools.

In addition to completing children's developmental screenings and assessments, CCDP projects must provide children with developmentally appropriate early childhood educational experiences. These experiences may include developmental programs for children provided in centers (CCDP-sponsored, Head Start, and other programs), home visits, or a combination of home- and center-based activities. In center-based programs, teachers and aides provide the intervention. In home visits, the intervention focuses on the parent or the other primary caregiver. The expectation is that parents will continue the intervention between home visits. Parents receive training in infant and child development as well as parenting in group educational sessions, resource centers, and home visits. In some cases, parents participate in parenting activities in the early childhood centers by observing and participating in classroom activities.

CCDP home visitors/case managers who provide early childhood education in families' homes spend an average of 41 minutes on planning each visit and devote an average of 45 minutes to early childhood education during each home visit. The Head Start Performance Standards (to which CCDP projects must adhere) require that the experiences stimulate physical, cognitive, emotional, and social development. An optimal learning environment should be provided to foster cognitive development through problemsolving, exploration, communication, and concept development.

Early intervention for children at risk of or with a diagnosed developmental delay must be provided in compliance with Public Law 99-457. Some projects mainstream children experiencing developmental delays in their center- or home-based model. Other CCDP projects provide services or refer children for specialized early intervention services. These services include activities performed by the regular teachers or by teachers with expertise and special training in early intervention. These activities may be carried out in the center or in the home. Some projects have specialists on staff to work with children who have hearing, speech, emotional, social, or physical delays.

Child Care

Child care is a mandated service under CCDP guidelines and is a crucial service in terms of its effects on both child development and parent employability. Child care must be State licensed or registered and meet Head Start Performance Standards if it is the only early childhood experience for CCDP children. Also, child care may be provided to parents who request it for respite or when the court has ordered child care for child protection. Projects also provide child care when it has been clinically determined that a child needs a center-based group developmental experience. In such cases, projects may provide families with child care through a developmental day care or a part-day developmental preschool program.

CCDP projects must ensure that child care is available and accessible to any parent requesting it when the primary caregiver is in training, working, or going to school. Child care centers, family day care homes, and child development centers must meet State licensing standards or certification. If the center also is providing early childhood education, the center must meet relevant Head Start Performance Standards, including the following:

- Appropriate adult-child ratios and group sizes;
- Daily and weekly schedules;
- Developmentally appropriate toys, equipment, and curricula;
- Culturally appropriate materials and staff;
- Training for staff on utilizing developmentally appropriate curriculum/curricula; and
- A documented mechanism to ensure that activities in center-based care or care in family day care homes will interface with developmental activities provided at home.

Since project inception, the need for child care has increased steadily as the CCDP parents become increasingly involved in furthering their education, in vocational training/employment, and in the programs offered by CCDP (e.g., basic skills classes, English as a Second Language [ESL] and GED classes, support group meetings, and other preemployment activities).

Some CCDP projects discovered that many day care facilities included in their original plans were inaccessible to families due to inadequate local transportation systems. One site indicated that its alternative strategy for increasing the number of available child care slots in the face of transportation problems (i.e., encouraging families to offer home care) turned out to be equally unfeasible, as the costs for home improvements and application fees created a financial burden.

Another problem faced by many projects is that they anticipated that State and county reimbursements would defray major parts of their child care costs. However, as projects placed children, they discovered that the reimbursements did not cover the costs and that they were responsible for the large differential. Child care facilities often charge up to $125 per week for their services, but State and local reimbursements defray only a fraction of this fee, with reimbursements ranging from $9 to $11 per day for infants and even less for toddlers. In some States, reimbursement funds through programs like the Family Support Act, Title XX, and CCDP became unavailable due to State budgetary problems aggravated by the recession. Many States chose not to provide matching funds to get their full allocation of Federal funds.

Solutions to Child Care Problems

Since the startup year, CCDP projects have developed innovative mechanisms for alleviating their child care problems. Most of the mechanisms involved the process of enlisting local families to provide day care in their homes for a nominal fee or restructuring the CCDP site so that limited care could be provided onsite for program participants. Solutions have included the following:

- Developing additional subcontractual arrangements with child care agencies;
- Employing a staff member to train families as day care providers;
- Providing monetary and technical assistance to those parents who demonstrate an interest in becoming family day care providers;
- Defraying fees involved in registering and remodeling the households of families willing to provide day care;
- Purchasing a large number of child care slots at a lower than normal rate;
- Negotiating arrangements with the local departments of education to provide child care in school facilities so that teenage parents can continue their educations;
- Employing the services of a child care consultant;
- Paying relatives of children to care for children as a temporary measure;
- Enlisting grandmothers to volunteer their time to provide onsite, short-term child care; and
- Applying for local grants earmarked for the development of improved child care arrangements.

For several projects, the lack of child care services in the community resulted in the development of CCDP child care centers. Ten of the twenty-one projects currently operate their own child care centers, and only 2 of the 21 projects report having insufficient child care slots available in their service areas. In addition, only 5 projects indicate that CCDP funds subsidize all or most of their child care needs; for the other 16 projects, approximately one-quarter or less of their child care costs are subsidized through CCDP funds. For one of the projects, all of its child care costs are paid for by non-CCDP funds.

Health Care and Nutritional Services

All CCDP families must have access to health care, and all health care services should be monitored and documented. The health care and nutritional services requirements for children are as follows:

- Health screenings and a comprehensive health assessment for children;
- Immunizations appropriate for the child's age;
- Well-baby and routine health care;
- Acute health care;
- Dental health care;
- Mental health care; and
- Nutritional services.

Each project has developed a model to deliver health care services including prenatal care, routine and acute care, health screening and assessment, immunizations, and other preventive care. The models differ widely with respect to their structures for service provision and staffing. The differences often are dependent on the type of grantee agency, the availability of and proximity to community health care providers, and the working relationship between the grantee and local health care providers. The routine preventive care provided by CCDP projects is discussed below.

All projects have developed linkages with clinics or medical centers to provide routine preventive care for CCDP clients. These health providers usually are located in close proximity to the families they are intended to serve. In some cases, the CCDP projects are located in facilities owned by a clinic or medical center with which the projects contract for health services. Other projects have asked collaborating health agencies to set up a clinic or offices for individual clinicians (such as a nurse practitioner) onsite at one or more of the project's multipurpose centers. Projects have made these arrangements to facilitate the provision of multiple services; for example, families can discuss case management issues on the way to or from a health appointment and can utilize the project's drop-in child care during their appointments.

Currently four projects provide health services onsite. The grantee agency of one of the four projects is a university medical center. Three of the four projects provide health assessments for CCDP children, one provides immunizations, two provide health screenings and physicals, and one provides vision screenings and dental services.

More than one-half of the projects also have established linkages with private physicians who served CCDP families before they enrolled in CCDP. Linkages with clinics or physicians often consist of written agreements stating willingness to collaborate, responsibilities of both parties (e.g., transportation, and completion of forms), and assurances of confidentiality. These linkages may include provisions for information sharing between the health and the project to facilitate case management functions. To quickly identify a patient as a CCDP participant, several projects have introduced the use of a program "card" that families carry with them when visiting a health care provider in the CCDP network.

Provision of health care by agencies or persons outside of CCDP is supplemented in many cases by systems developed within CCDP. Twelve projects have a health specialist such as a doctor, nurse, or medical director either directly employed by the project or assigned to the project through a contractual agreement. These persons may supervise, coordinate, or provide direct services (such as screenings) for the health component of the CCDP project. For instance, the coordinator of medical services at one project is a pediatrician whose responsibilities include communicating with major area health care providers, meeting weekly with home visitors, reviewing charts, and providing consultation and recommendations regarding family health care needs.

Five projects provide some health services in home visits. Four of these are rural projects that use home health visits to avoid transporting families long distances. The purposes of these home visits range from conducting health screenings and compiling a medical history for the family to providing prenatal care and monitoring the overall health conditions and practices of the family members. Three of these projects have public health nurses visit the families. At the other two projects, a health coordinator makes home visits periodically to conduct health screenings and to collect information on family members' health histories and conditions. One project has assigned public health nurses the dual roles of monitoring families' health care needs and coordinating the case management provided through home visits. The health care specialist visiting the home provides only preventive or routine care and coordinates referrals to other health care settings for treatment of acute health care problems.

Core Services for Parents and Other Household Family Members

This section discusses the availability of core services for parents and other family members of the same household who provide major nurturance to the focus child, including the following: (1) parent education; (2) adult education, vocational training, and job training; (3) routine and acute health care; (4) mental health care; (5) substance abuse services; (6) assistance in securing adequate housing; (7) income support; and (8) transportation. Each of these core services is discussed below.

Parent Education

The criteria for the provision of parent education to CCDP parents are as follows:

- Training must be provided to parents for infant and child development, health care, nutrition, parenting skills, and life skills/functioning (e.g., budgeting). This training may be provided through CCDP center-based or home visit training or through a contracting/interagency agreement if the training is accessible to parents and procedures have been established to monitor the training.

- Adult group activities that provide mutual support must be available to program parents.

As a holistic program that focuses on the many needs of low-income families, CCDP is committed to providing a well-rounded agenda of educational activities to improve families' abilities to care for themselves. Parent education may occur in the families' homes or in group settings. Topics for instruction include child development and childrearing, health care, and nutrition.

The parenting education component involves several issues such as choosing a curriculum, training staff and parents, and ensuring that parents participate in this aspect of the program. Lessons learned by CCDP project include the following (CSR, 1992):

- When choosing curricula for parenting education, it is important to consider their cultural appropriateness and the values of the targeted population.

- Training should be provided for staff and families that addresses the following:

  - Staff training on the curricula (or the approaches) for parenting education should be provided to all appropriate staff, including home visitors with case management and early childhood education responsibilities.

  - Inservice training workshops should take into account that staff who are not parents have special training needs.

  - Staff need to be knowledgeable about cultural perspectives in regard to issues such as childrearing techniques.

  - Training should be sequential. For example, workshops should have specific goals and predetermined beginning and ending dates, and parents should receive a certificate of attendance/completion.

  - Trainings should not duplicate those offered by other community programs (e.g., the Special Supplemental Food Program for Women, Infants, and Children [WIC] conducts nutrition training workshops that may be similar to what CCDP offers).

The parenting education curricula most often used by CCDP projects are the following: Parents for Learning, STEPS Program, Parents as Teachers, On Base, and Good Beginnings.

In-Home Education

Many parent education activities are provided in the home by the home visitor. This setting allows for parental education to be provided in a nonthreatening environment and facilitates one-on-one instruction. Home visitors provide instruction in parenting and child development while they work with the parents and CCDP children. Home visitors also encourage parents to raise issues of specific concern.

Topics relating to nutrition often are discussed in the home as the home visitor discusses with parents the eating habits of children and other family members or assists in the preparation of a nutritious meal or snack. Programs vary in the degree to which they emphasize nutrition education in homes, often depending on staff expertise and training.

Topics related to the health of the child and the family as a whole may be raised during home visits; the home visitor encourages and assists parents in visiting health care practitioners for routine visits and immunizations for their children.

Out-of-Home Education

Parent education also occurs in group settings regularly scheduled at project facilities or other community agencies. Professional CCDP staff, consultants, and specialists from other agencies conduct educational and/or support group sessions on a range of topics from child development to nutrition to job-seeking skills.

Nutrition education, for example, often is provided by the county extension agent or a health department nurse who works with the project under an interagency agreement to provide nutrition training in specially convened parent groups. This offsite training has the advantage of allowing specialists to supplement their presentations with audiovisual support and hands-on experiences.

Adult health and general health issues usually are discussed in clinic settings. When parents attend clinics for routine visits for themselves or their children, providers take the time to provide CCDP families with instruction about healthful practices and behaviors and make recommendations for health-enhancing changes in their lifestyles.

Strategies for Increasing Parent Participation

During startup, CCDP projects experienced low participation rates in parenting activities. CCDP project directors found the following strategies successful in increasing parent participation in parent education classes (from CSR, 1992):

- Trust must be developed between parents and staff so that group support meetings become more important.
- Parents must be consulted about the topics they would like to discuss, because the most successful activities are the ones in which the parents have an interest.
- Popular topics should be discussed, including cooking, breastfeeding, health, birth control, and substance abuse prevention.
- Classes and meetings should be held at convenient times, both during the day and in the evening.
- Parents should be given responsibility for teaching some of the groups.
- Personal interactions among parents should be encouraged to foster participation by parents.
- Child care should be provided at the same facility where the classes are held.
- Staff must be prepared to deal with serious issues such as abortion, drug use, and physical abuse. These issues often arise during parent support groups and classes.

Involvement of Males in Project Activities

Low participation by males (husbands/partners) is a problem confronted by all CCDP projects. Projects have found that certain strategies are successful in increasing male participation. These strategies include hiring male staff at all levels (e.g., the van driver, who is usually male, is extremely important for outreach); placing a focus on total family involvement instead of having separate activities for fathers, mothers, or children; and involving all members in the family needs assessment. In addition, projects found that men should be encouraged to become interested in the betterment of their families, not just in participating in the program activities. Getting men involved in CCDP activities is a developmental process that takes time and demands a sustained effort.

Adult Education, Vocational Training, and Job Training

Criteria for the availability and provision of adult education, vocational training, and job training are as follows:

- Adult literacy education, vocational training, employment counseling, and job training/placement must be available to all program families requesting these services; and
- When these services are arranged through contracting agencies, they must be accessible and provided in a timely manner.

Adult Education

In support of the CCDP goal of assisting CCDP families in achieving economic and social self-sufficiency, projects offer a wide array of adult education programs. These programs provide training in the following areas: literacy, basic skills, skills for daily living, GED, and ESL. To build on educational resources in the community, projects have developed several arrangements, including referral networks, to ensure that families' educational needs are served adequately. These referral arrangements are negotiated with community colleges and other local educational institutions that already are serving the community.

Four projects provide adult education in-house and have hired specially trained staff members to conduct ESL classes for family members and/or have contracted with local colleges or county extension agents to train CCDP staff to provide instruction in basic living skills. This allows families to receive instruction, often from staff members they already know.

Although the adult education and job training component is not operational during the early stages of CCDP, project directors had planned ahead to meet this need. Most projects have an adult education/employment coordinator on staff, whose sole responsibility is to coordinate this aspect of the project (CSR, 1992). The coordinator is usually a full-time employee so that this person may more effectively oversee the different aspects of this service. Project directors also have discovered that during the later stages of a project, it often is necessary to employ two staff persons to oversee the job readiness and job search/brokering component. Many of the activities in this component have to be provided by the CCDP staff (especially job placement) because Federal and State programs, such as Job Opportunities and Basic Skills (JOBS), do not focus specifically on building careers.

Linkages with existing community programs that assist in or provide job training for low-income families facilitate the provision of this service component. To facilitate these linkages, many projects recruit members of community agencies and the business community for their advisory councils.

Community agencies and programs with which CCDP projects have established linkages include the following:

- Local universities and junior colleges;
- Local secondary schools and vocational schools;
- The JOBS program;
- The Job Training Partnership Act (JTPA) program;
- Local employment councils; and
- Community business councils.

Vocational Training

Various resources exist in communities to provide vocational training to CCDP project families. These include community colleges, high schools, vocational centers, State employment and training facilities, departments of social services, and JTPA grantees. The services provided by these agencies vary greatly, particularly with respect to client assessment and counseling and placement assistance. The services also vary greatly with respect to their availability. Projects that rely on JTPA for vocational services, for example, often cannot ensure placement slots for their clients at the end of the fiscal year, as JTPA grantees await refunding.

Only one CCDP project provides vocational services directly through the project. The remaining projects rely on a combination of interagency agreements and referrals to place clients in appropriate vocational training settings. In one midwestern site in which many families are interested in the development of small businesses, the project has signed a contract with a small business development specialist who provides "entrepreneurial training." In the course of his training, the specialist provides intensive assessment and counseling to family members on a one-to-one basis over extended time periods.

Job Training

CCDP projects have found it necessary to consider the following factors when implementing job training programs (from CSR, 1992):

- It is important to have a budget for the adult education component. This money can be used to provide assistance in paying previous educational loans, paying for special courses, or establishing a scholarship fund.

- To prepare CCDP parents for employment searching, workshops need to be conducted on such topics as résumé writing, interview skills, job retention, and behavior in the workplace.

One of CCDP's pivotal goals is to promote career development, not just job training and readiness. It is therefore necessary to interest families in long-term plans and to work step by step toward the implementation of the plans. Career development goals include the following:

- The first goal should be for parents to complete high school. Only after a person has the equivalent of a high school education can job-readiness training begin. Some parents want to begin or complete a college education. Projects help parents obtain grants or loans to make this a reality for them.

- Parents should be ready for and interested in a particular job before they are placed. Sometimes parents need to start at an entry-level position at minimum wage.

- When parents begin their search for employment, project staff should facilitate personal contacts with companies and employers in the project's community. Several CCDP projects have established special programs with businesses. For example, some companies identify staff persons within the companies to serve as mentors, and in some cases companies provide internships so that individuals can develop experience.

- Parents should be trained regarding behavior in the workplace (e.g., dress codes and the importance of punctuality) in order to facilitate job entry and retention.

Job Development and Job Placement

Promoting self-sufficiency within CCDP involves the provision of services specifically targeted to parents for the benefit of the family or of the parents themselves. Job development and job placement are among the services provided to help CCDP families move toward self-sufficiency. CCDP (projects establish linkages with major employers and agencies, develop formal interagency agreements, enlist the help of advisory board members, arrange adult group activities that provide mutual support to families, and establish mechanisms targeted at increasing male participation and involvement in the program.

Each CCDP project has a designated staff member who functions as an employment coordinator. The employment coordinator's job development and job placement activities include the following:

- Developing, monitoring, updating, and utilizing contacts with private and public labor market sectors in an effort to secure meaningful employment opportunities, as well as attempting to solicit services of retired Chief Executive Officers or personnel managers to help with establishing those contacts;

- Connecting applicants with suitable employment opportunities, monitoring the progress of employed program participants, and revising employment/training goal and activity plans to reflect the next level of goals to be achieved; and

- Providing followup services for CCDP participants placed in jobs (e.g., acting as a supportive liaison between employers and employees).

The Fourth Ethnographer's Report (1991), prepared by CCDP ethnographers, examined the role of job development and job placement in CCDP. The ethnographers were asked to describe how projects define and execute the process. The following is an example of one project's approach, as described by the ethnographer:

> The Job Training and Employment Coordinator worked together with a councilwoman's office to organize a job fair, attended local job fairs, written letters to donors and volunteers, and communicated with members of the grantee agency's Board of Directors asking for their assistance in finding employment for program families; written similar letters or provided presentations to local employers (e.g., a flower shop, carpet company, hotel, food service); helped get information about the program disseminated through the local Chamber of Commerce newsletter and a local newspaper; and contacted various JTPA programs operating in the target area.

The process of providing job-related counseling and services involves the cultivation of contacts with various agencies by the employment coordinator, the suggestion of names of program participants by case managers, and the development of long-term and short-term plans for the individuals in need. Carrying out these plans requires the use of community resources for testing, training, and placement.

Routine and Acute Health Care

CCDP projects must, on an as-needed basis, provide for prenatal and postpartum care and routine and acute health care. All projects have developed arrangements and agreements with hospitals or local public health departments to ensure that all family members receive acute health care when necessary. However, it has been more difficult to establish a service delivery system to meet adults' health care needs, particularly in the area of acute health care provision. Although most CCDP adults are eligible to receive medical care through their participation in medicaid (or their State's equivalent), a number of families include members who are employed and may be ineligible for medicaid. As a result, the role of the CCDP case managers may include assisting uninsured adults in locating cooperating physicians who will provide them with services on a no-cost or low-cost basis.

One of the pivotal goals of CCDP is to promote early prenatal care for CCDP project mothers. Health coordinators and case managers work closely with families to encourage them to seek early and continuous prenatal care. Although health services are offered by CCDP and by cooperating agencies, many families do not take full advantage of what is available. Many CCDP mothers are reluctant to visit the doctor for prenatal care, especially women who have had several children. To deal with this problem, some projects try to teach families about available health services other than those needed during an emergency. For example, some projects provide instructions on how to access the health care system.

In addition, activities such as exercise and aerobics classes and diet programs are used by projects to increase health and nutrition awareness. Several projects also have held health fairs, which have been popular with CCDP families.

Mental Health Care

CCDP projects must provide mental health care as needed. This type of support generally is provided to families through interagency agreements with local mental health centers or contracts with private mental health agencies. Services provided by these agencies include individual and family therapy, marital counseling, alcohol and other drug counseling, and treatment for dysfunctional or aberrant behavior. Persons with more serious problems are referred to inpatient treatment facilities.

CCDP projects also are encouraged to provide support for preventative mental health services. A mental health coordinating function has been added to facilitate this process. The function is primarily focused on working together with case managers to enhance the self-esteem and self-efficacy of CCDP family members. Eight projects have a mental health component that is both preventative and therapeutic oriented (see Exhibit 2-21 following the next page). While a project may have interagency agreements with agencies or clinics, it is usually the mental health specialist who performs the initial evaluation and assessment and then provides the referral to an offsite facility. Also, the mental health specialist often will train case managers on how to work with families that are experiencing mental health problems.

In addition to mental health services provided through onsite staff and interagency agreements, some projects also provide weekly and biweekly support groups to families. The groups usually are conducted by a project staff person and have different themes. For example, several projects have support groups that discuss self-esteem, motivation, physical/mental/ sexual abuse, and life experiences.

Substance Abuse Services

Substance abuse education and treatment are provided by CCDP projects as needed. Most projects respond to family problems associated with alcohol and other drug abuse through contracts and interagency agreements with drug and alcohol treatment centers, health centers, and alcohol rehabilitation centers, which provide intensive counseling and outpatient care. Grantees have signed either agreements for these purposes or are in the process of negotiating agreements.

While all project staff may be trained in some substance abuse issues, the case manager is generally responsible for detecting and identifying whether any family members are involved in substance abuse. If substance abuse is suspected, the case manager usually meets with his/her supervisor, and (if available) the onsite substance abuse or mental health specialist(s) will arrange a meeting with the family. If a family member is to enter treatment, an evaluation and assessment are performed, and then a referral is made to the appropriate facility.

Many CCDP families are in recovery and/or still abusing drugs or alcohol but want to overcome dependency. Projects show their support of these families by providing assistance with substance abuse treatment in addition to other core services.

Case managers report that low-income families in isolated communities tend to use alcohol to replace the social interaction that is more accessible to city dwellers. Project families who live in inner cities are more likely to use highly addictive drugs, such as crack-cocaine and cocaine, rather than alcohol.

Assistance in Securing Adequate Housing

The provision of adequate housing is another major factor in helping families move toward self-sufficiency. A major goal of CCDP is to help families find and maintain adequate housing. Case managers help families procure adequate housing through establishing linkages with housing authorities, developing formal interagency agreements with housing providers, and enlisting the help of advisory board members who are in decisionmaking positions in agencies that provide housing to low-income families. Case managers provide information and assistance to families looking for housing primarily by helping families clarify and set goals and by making referrals to other agencies. CCDP projects ensure that families are able to pay their housing expenses through access to emergency funds (i.e., utilities assistance, emergency housing funds, and other relief) when needed.

The Fifth Ethnographer's Report, prepared by CCDP ethnographers, examined the process of assisting families in securing adequate housing. The ethnographers were asked to describe how individual CCDP projects assist families in securing adequate housing. The following is an example of one project's approach, as described by the ethnographer:

Exhibit 2-21

Mental Health Component Characteristics

CCDP Project	Preventative Mental Health Component	Treatment-Oriented Mental Health Component	Combined Mental Health Component
Community-Family Partnership			✓
Project Family	✓		
Project CHANCE	✓		
Windham Co. Family Support Program	✓		
Project EAGLE			✓
Family Futures			✓
Project Focus			✓
ShareCare	✓		
ENRICH		✓	
Primero Los Niños	✓		
Project AFRIC		✓	
Family Foundations	✓		
Families in Partnership		✓	
Family Start		✓	
Tennessee CAREs			✓
Families First			✓
AVANCE			✓
West CAP Full Circle Project			✓
Conocimiento*			
MICA*			
Operation Family*			
Total (21 projects)	6	4	8

*At the time of this report, no information was available from this CCDP project.

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> The CCDP staff most involved in dealing with housing issues are the case managers. It is they who talk with family members about housing needs and concerns and it is mostly [the] case managers who make contacts with other agencies in terms of trying to resolve housing problems. [C]oordinators oversee this work and also bring up housing issues for discussion in program development meetings. This includes both specific cases—e.g., the family who is dealing with lead poisoning—and overall housing policies and problems—such as the increases in rent tied to employment and income. The project director in her bi-weekly meetings with case managers also discusses housing issues and carries out training around housing programs. Requests for emergency funds to help with rent and/or utilities are discussed....at the team meetings of project staff....Staff of the Urban League and Housing Authorities have been invited to these meetings to help in the training and orientation of the case managers in relation to housing issues.

CCDP cannot guarantee that all program families will live in safe environments, but projects can help families achieve this goal by assisting and motivating families to find safe housing. The coordination that currently exists between the CCDP projects and housing agencies occurs at both the administrative and the staff levels. Most of the interactions occur at the staff level, with staff providing families with information and making referrals to housing agencies.

Income Support

Many CCDP families are eligible for several forms of income support, including Aid to Families with Dependent Children, food stamps, and medicaid. Responsibility for this assistance usually lies with States' departments of social or human services. Most CCDP projects have formalized their relationships with these agencies, thereby facilitating client access and encouraging communication between the CCDP projects and the welfare agencies. For example, some welfare agencies have agreed to designate specific staff members to serve all CCDP families to avoid the problem of families getting "lost" in the system. However, in other projects, social services agencies have felt that they must treat all clients equally and not make special provisions for CCDP families. In both cases, CCDP project staff members frequently serve as advocates for families to facilitate their receipt of the services for which they are eligible.

Transportation

CCDP projects must provide adequate transportation to ensure that all families are able to access core services. This requirement has been a major difficulty for some of the grantees, especially for the rural or very isolated sites. However, projects are making transportation available to families by providing tokens, hiring cabs, or reimbursing staff for providing transportation in their own vehicles. Many of the projects have purchased or leased one or more vans and have hired part-time drivers.

CCDP staff who transport families of projects located in rural areas often use the driving time to conduct case management activities. Staff have provided transportation to families for doctor appointments, job interviews and training programs, appointments at DHHS and WIC sites, and counseling sessions.

DISCUSSION OF NONCORE SERVICES

The previous sections of this chapter discussed legislatively mandated core services that CCDP projects are required to make available for children, parents, and other household members. This section presents an overview of services provided that are not legislatively mandated. Since CCDP is a total family support program, such services are considered important to the overall functioning of the families. As such, CCDP projects are encouraged to offer these services and activities based on family or individual family member needs and goals.

The data for this discussion were derived primarily from the grantees' quarterly progress reports and other qualitative data sources, such as project directors' or advisory board statements. Selective illustrations of the following categories of noncore services and activities are presented:

- Programs for teen parents;
- Recreation and socialization opportunities;
- Legal assistance;
- Volunteer programs;
- Emergency assistance;
- Loan funds;
- Parent advisory councils;
- Advocacy; and
- Forums for participant feedback.

Exhibit 2-22 following this page graphically summarizes which CCDP projects provide which noncore services. As can be seen, many of the services and activities are provided by all or a large majority of the projects. Relatively few projects provide programs for teen parents, loan funds, or legal assistance.

Programs for Teen Parents

CCDP projects are required to ensure that recruited families are proportionately representative of the economically disadvantaged population of the grantee's recruitment area in terms of two strata: ethnicity and age

Exhibit 2-22

Other Services/Activities Provided for CCDP Parents and Other Household Family Members

	Loan Fund	Legal Assistance	Volunteer Opportunities	Recreational/Social Opportunities	Parent Council*	Programs for Teen Parents	Development/Fund Raising/Advocacy	Forums for Participant Feedback	TOTAL
Project AFRIC		✓	✓	✓	✓		✓	✓	6
Windham County Family Support Program	✓	✓	✓	✓	✓	✓	✓	✓	8
Project Chance		✓	✓	✓	✓	✓	✓	✓	7
Family Start		✓		✓	✓	✓	✓	✓	6
Family Foundations	✓		✓	✓	✓		✓	✓	6
Operation Family		✓	✓	✓	✓		✓	✓	6
Tennessee CAREs	✓	✓	✓	✓	✓		✓		6
Project Focus	✓		✓	✓	✓	✓	✓	✓	7
West CAP Full Circle Project	✓	✓	✓	✓	✓	✓	✓	✓	8
Project Family	✓		✓	✓	✓	✓	✓	✓	7
City of Albuquerque CCDP			✓	✓	✓		✓		4
Primero Los Ninos	✓	✓	✓	✓	✓	✓	✓	✓	8
Avance CCDP	✓	✓	✓	✓	✓	✓	✓	✓	8
ShareCare Program	✓	✓	✓	✓	✓		✓	✓	7
Mid-Iowa Community Action			✓	✓	✓	✓	✓	✓	6
Project EAGLE	✓	✓	✓	✓	✓	✓	✓	✓	8
Family Futures	✓	✓	✓	✓	✓	✓		✓	7
Community-Family Partnership Project		✓	✓	✓	✓		✓	✓	6
Conocimiento		✓	✓	✓	✓		✓	✓	6
ENRICH		✓	✓	✓	✓	✓	✓	✓	7
Families First	✓	✓	✓	✓	✓	✓	✓	✓	8

*CCDP projects are required to make these services/activities available to families.

of primary caregiver (teenager or not). Projects have been slow in developing special programs for these teenage parents. However, as programs become stabilized, they are focusing more on this group. The services and activities made available to teen parents at two CCDP projects are described below.

Three teen mothers at Project Focus are benefiting from the Traveling Grannies Program, which was created under an agreement negotiated by the CCDP project director with the State Gerontology Network. The aim of this partnership is to help and train adolescent mothers who have little income or family support. The "granny" provides 5 to 6 hours per week to her "adopted granddaughter," helping with and teaching childrearing, cooking, schooling, transportation, and other necessities. The granny's efforts provide support to the CCDP home visitor/case manager. The granny gives hands-on parenting education in areas such as baby care, nutrition, housekeeping, budgeting, and grocery shopping. The granny also serves as a role model and, in some cases, as the young mother's best friend.

Family Futures is one of the few CCDP projects that provides a "Teen Parent Advocate" (TPA) component in its program. The TPA program manager conducts monthly workshops and classes targeted specifically to pregnant and parenting teens. The TPA program manager and a case manager hosted a "Back to School" session, in August 1992, in which they offered advice and assistance to teenage parents interested in returning to high school or participating in another educational program. The TPA program offers a series of workshops on job-readiness skills (including résumé writing, interviewing techniques, and appropriate attire and grooming) and has home-based lesson plans for teens to review financial management and to learn exercises for improving self-esteem. During the project's Family Camp, a relationship forum was sponsored for 20 participants, including teenage mothers and fathers, to discuss issues regarding intimate relationships. The parents all have requested a followup session.

Recreation and Socialization Opportunities

The high incidence of crime and violence that exists in communities in which CCDP families live has limited the families' opportunities for engaging in safe community recreational and socialization experiences. As a consequence, many low-income families have become socially isolated. Several CCDP projects have made a special effort to mitigate the effects of this isolation by providing opportunities for CCDP families to meet and socialize with one another in a safe environment.

Project AFRIC family members enjoy monthly parents' socials; movies for adults and children; holiday parties; trips to the circus, theater, and ballet; picnics at State parks; summer camp for the 5- to 13-year-olds (46 attended); storytelling and dance contest events; and door prize drawings to encourage attendance at the parent advisory council (PAC) meetings.

Project C provides similar activities. During the year parents and children watch movies, hold holiday parties, and attend the theater. The project also has sponsored a spring children's carnival and special programs that facilitate interaction between the mothers and their children. Throughout the summer, 21 children took part in the Positive Image Program, which provided games, sports, and field trips to a variety of places, including the library, ballparks, zoos, and botanical gardens.

Having access to such recreational and socialization activities appears to help family members relieve the stress of living in low-income neighborhoods, to mitigate the effects of social isolation, and to foster a sense of community and hope.

Legal Assistance

Low-income families have difficulty accessing legal assistance due to a paucity of resources or lack of necessary funds. Although the public defender system and law school pro bono programs bridge some of this gap, legal aid remains well beyond the resources available to most low-income families. To address this need, several CCDP projects have arranged for legal assistance for their families. Three examples of such assistance are described in the following paragraphs.

- One CCDP project, Avance, has arranged—at no cost to the family—for the provision of legal advocacy to handle traffic violations, fine requirements, plea bargaining for personal recognizance bonding, the preparation of wills and affidavits of heirs, and U.S. Immigration and Naturalization Service citizenship dispositions.

- Tennessee CAREs provided legal assistance and referrals to a program mother who needed a divorce before her bank application for housing could be approved. In another case, project staff collaborated with local lawyers to assist in the preparation of a CCDP participant's child custody case.

- Family Futures has facilitated "legal audits" to be performed by the local legal aid and legal services organizations. This service assists with any legal issues confronting CCDP family members and explains their rights with regard to issues such as child support or a defaulted student loan—all at no cost to the family member. The audits consist of indepth interviews conducted by the Legal Aid Society with individual family members. Following the interviews, the audits are reviewed by a staffing committee that identifies legal problems and refers the clients either to staff attorneys from the Legal Aid Society or to volunteer attorneys from the State Lawyers Committee.

Family Futures volunteer attorneys assist with most of the legal problems that project families face. The volunteer attorneys maintain ongoing relationships with the families and are able to follow up on their progress and handle any new legal issues that may arise.

Volunteer Programs

One way to help foster a low-income family's sense of ownership in CCDP projects and in their communities is to provide opportunities for volunteering to help improve the CCDP and the larger community. Examples of parent volunteer programs are described below.

Families First provides adult family member volunteers with free management training in all facets of running the project's clothing bank. During the last fiscal quarter, 11 parents participated in 31 sessions of management training. This training focused on the organization and implementation of the library system, on inventory, on quality control, and on stock work. Parents also volunteered to participate in such activities as the PAC; the management and production of the project newsletter; the child care cooperative; the advisory board; and miscellaneous tasks, such as painting signs and administrative duties.

Volunteerism also is a source of resources outside the program. Many CCDP projects provide volunteer opportunities for community members. For example, in Families First, community volunteers planted trees; cleaned up, landscaped, and repaired the project property; helped child care providers; ran recycling programs; and—together with project parents—helped organize and manage the project's clothing bank.

The Albuquerque CCDP's community volunteers conduct one-on-one employment and training needs interviews. To date, a total of 140 of these interviews have been conducted, with the assistance of one university intern.

Some projects benefit from significant amounts of time contributed by community volunteers. In one 12-month period, ENRICH benefited from 1,885 hours of community volunteer time for the following types at services:

- Child development services;
- Legal services;
- Social services;
- Clerical services;
- Planning services;
- Job development;
- Parent education;
- Parent council work;
- Translator services;
- Research services;
- Librarian services;
- Psychiatric services; and
- Staff training services.

Emergency Assistance

CCDP families often face recurrent crises that can interfere with their ability to attain economic and social self-sufficiency. Some of these crises include the inability to pay rent or utility bills, lack of basic necessities such as food or clothing, medical emergencies, damage to housing resulting in abandonment of the residence, lack of money to repair a car necessary to reach a job, or the inability of unemployed individuals to pay for job training.

During site visits to CCDP projects in their startup phase, it was observed that CCDP staff spent significant amounts of time dealing with family crises (see CSR, 1991). It was evident that if CCDP projects were to help families achieve self-sufficiency, they needed to identify sources of emergency assistance in the community or to provide emergency assistance directly. All CCDP projects currently provide such support to program families. Several examples of emergency assistance activities provided by CCDP projects are described below.

The Windham County (Vermont) Family Support Program distributes CCDP funds to help with needs such as the following:

- Replacement of a broken electric water heater by a more efficient one fueled by natural gas;
- Training for a father to obtain a commercial tractor trailer driver's license;
- Security deposit for a new natural gas account;
- Payment for a first-time oil delivery;
- GED examination fee and physical examination fee (both required for a vocational training program);
- Rental security deposit and/or rent;
- Weatherization of a home;
- Food;
- Fuel, auto repair, auto insurance, and/or auto insurance payment;
- Utility payments; and
- Lawyer fees for a custody hearing.

Over the course of 1 year, Families First provided emergency assistance in 562 situations. These emergency assistance grants included the following:

- 234 grants (41 percent) for transportation, including bus tokens (118), gas vouchers (110), car insurance (2), and car repairs (4);
- 144 grants (26 percent) for food (81), clothing (34), and diapers (20);
- 64 grants (11 percent) for housing-related expenses, including utility bills (38) and rent (26); and
- 120 grants (21 percent) for other emergencies, including funds to complete training/education programs (28), medical emergencies not covered by insurance (49), furniture replacement (15), emergency storage (2), and miscellaneous (26).

Operation Family brokers emergency services for CCDP families. The organization convinced other local organizations that, by providing emergency assistance in the community, they could redirect their efforts to provide more assistance to families working toward self-sufficiency. This has resulted in the following impacts:

- Operation Family assisted with nonemergency funds for such items as tuition, clothing, school supplies, and books.
- Volunteers in these and other similar organizations provided food and gifts at holidays and have "adopted" families to provide one-on-one support.

Loan Funds

Another major difficulty faced by low-income families involves obtaining loans for housing, cars, education, and other items or services that could help families achieve self-sufficiency. Unlike emergency assistance, loans provided by CCDP projects must be paid back, often at reduced interest rates. Usually the loan fund is administered in cooperation with a local bank which handles some or all administrative, fiscal, and clerical duties. The provision of low-interest loans serves two main purposes: (1) the loan helps meet a critical economic or social need and (2) families learn about the process of applying for a loan and budgeting for the repayment of the loan. A description of an exemplary loan program follows.

West CAP Full Circle Project, a rural CCDP project, provides two types of loans: (1) participant self-sufficiency loans and (2) child care development loans. As of March 31, 1993, the CCDP had approved 64 self-sufficiency loans totaling $59,650, for an average of $932 per loan. The most frequent reasons for requesting loans were for the purchase of a used car or for the purchase of auto insurance. Repayment of the loans has been remarkably consistent, with only a handful of defaulters. Defaulters are involved in developing an alternate payback plan, such as reduced payments or by working off their balance by assisting with program activities or with facilities maintenance.

The Child Care Development Loan Fund is intended to provide loans to existing and potential child care providers to assist them in providing care for additional children or to enhance the provider's current program. This fund has impacted both the quantity and quality of child care available to families in the area.

The importance of providing these loans is summarized as follows by a county human services representative:

> I want to take the opportunity to express what an asset the CCDP has been to our...area. There are many reasons why this project is an asset. The foremost of these are the two loan funds, the Participant Self-Sufficiency and the Child Care Development Loan Funds. Both of these funds have had an extremely positive impact on project participants and child care providers.

Parent Advisory Councils

Although CCDP projects are required to include parents on their advisory boards, another opportunity for parent input and ownership is provided by the PAC's. PAC's, which are made up entirely of program parents, serve as the voice of all program parents in communications and discussions with the advisory boards, the project staff, and representatives of other community agencies. In some cases, the PAC's are responsible for selecting or electing parents who serve on the program's advisory board. This volunteer opportunity provides two-way communication between parents and staff as well as parents and community leaders.

PAC's manage newsletters, help with home visits and training sessions, and conduct policy group meetings. Parents can assist staff in setting the goals of the local program and of other community institutions concerned with children and families, which allows parents and staff to see these goals as an interrelated system. An example of the types of activities in which PAC's are engaged is provided below.

Program Chance's PAC manages an ongoing and successful food cooperative, which created and maintains a linkage agreement with a local public housing project's tenant association. This agreement provides for the residents of the housing project to become members of the cooperative. These parents have taken full responsibility for implementing and administering the food cooperative.

Advocacy

Some projects advocate for their community and thereby provide the opportunity for participants to advocate for themselves and for their neighbors. The following letter is taken from the MICA (Iowa) CCDP newsletter:

> On Community Planning Day, April 21, 1992, 7,000 participants of all ages and from all walks of life joined the circle of people who came together in homes, schools, and churches throughout five adjacent counties in a large mid-western State to reaffirm their values about families and offer strategies for translating those values into reality. They talked about ways to ensure that all families and children have the opportunity to be safe, educated, productive members of their communities.

This event was sponsored by MICA in cooperation with a coalition of 50 human services organizations and educational institutions from 5 local counties. This collaborative effort had, for the previous 18 months, addressed issues affecting these at-risk children and families.

In fall 1991, MICA received a $200,000 grant from DHHS to lead the coalition in a community planning project. MICA was one of only three family services agencies throughout the Nation to receive this community coalition funding from DHHS and was the only project operating in a rural area.

To involve young people in this community planning process, middle schools and high schools in each of the 25 school districts used the program materials in classroom activities to allow students to share their ideas about what it takes for families to be successful in their communities.

Having struggled with many family-related concerns for some time, the coalition and its members knew that before significant changes would occur in the way communities responded to at-risk families and children, a much larger number of people needed to be drawn into the discussion about risk issues.

The strategy of holding 1,000 meetings in homes, schools, churches, and townhalls was designed to access ideas from the largest possible number of people. The coalition thought that if the meetings were held by people from all walks of life and if hosts could invite anyone to attend, then the coalition would gain the largest diversity of ideas and opinions, thus virtually guaranteeing that all viewpoints would be represented when the community plan's development began.

Community Planning Day provided residents the opportunity to express their own values about youth and families and to have input into strategic decisions with regard to how to establish those values in the community.

More than 1,500 of the original participants elected to take part in Phase 2 of the process by forming task forces in 19 communities to further analyze and research the issues on local, county, and regional levels and to make recommendations to the coalition. The intent was to consolidate the work of all the task forces into a communitywide and community-based plan of action to increase the well-being of families. Each task force's recommendations are being incorporated in a formal community plan to bring about structural changes in the human services and education systems, to shape community values, and to impact public policy so as to create a social climate that nurtures the continuing growth and development of all community members.

The coalition is seeking formal endorsement of and commitment to the plan from local community leaders and decisionmakers through a series of presentations to city councils, county boards of supervisors, school boards, and boards of directors of human services organizations. The coalition is asking these bodies to do what is necessary—be it redirecting or allocating resources, making changes in the way services are delivered, or advocating at a State or national level to change policy regarding a particular issue—to activate the plan.

Forums for Participant Feedback

CCDP families find additional avenues for input in the form of participant surveys and family grievance procedures. An example of such a procedure is administering questionnaires to participating parents and agency personnel. These avenues represent vehicles to facilitate the collection of valuable data on participants' satisfaction (or lack thereof) with CCDP services.

The Avance CCDP project mandates that all its case managers provide their families with a written copy of Avance's grievance procedure and must discuss the procedure with all the project's families. The procedures require that families and case managers must make every attempt to resolve disagreements and that the case management coordinator be informed of the situation. If necessary, a meeting is scheduled by the case manager to include the family, the case manager, and the case management coordinator. The procedure further provides that if the case is not resolved at this level, the family has the option of scheduling another meeting that includes the project director.

MICA created two survey instruments: one for families to measure their satisfaction and one for coordinating agencies to rate the project's effectiveness to date and to identify programmatic issues of concern. The Family Satisfaction Survey asked families to rank MICA on 40 different areas and aspects of services on a scale of 1 to 5 (1 indicating "not at all satisfied," and 5 indicating "totally satisfied"). MICA averaged 4.1 out of 5 on the 40 services and issues. The Family Satisfaction Survey also asked for input from the participants regarding their interest in additional services and need for additional information. Participants asked for more family recreational activities (73 percent), children's activities (69 percent), a men's support group (15 percent), and job clubs (19 percent). Families asked for more information about "How to see the world through my child's eyes" and "How to help my child stay away from drugs and alcohol."

Project Focus measured families' satisfaction in seven areas, using a survey distributed by home visitors during their home visits. Parents were asked to complete the survey and mail it to Project Focus in postage-paid envelopes. Of 100 surveys distributed, 56 were returned. Project Focus averaged 7.29 on the satisfaction scale of 1 to 8 (8 being "very satisfied").

REFERENCES

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PART II. PROCESS EVALUATION

Chapter 3. Conceptual Framework for Feasibility Analysis and Process Evaluation Models

Chapter 4. Projects' Lifecycles

Chapter 5. Attrition (Terminations) and Family Satisfaction

Chapter 6. Family- and Individual-Level Needs, Service Receipt and Utilization, and Goal Attainment

Chapter 7. Community Effects

Chapter 8. Cost Analysis

Chapter 3. CONCEPTUAL FRAMEWORK FOR FEASIBILITY ANALYSIS AND PROCESS EVALUATION MODELS

The implementation of the Comprehensive Child Development Program (CCDP) has been a complex undertaking, with many features contributing to this complexity. For example, the following features have combined to make CCDP startup a challenging undertaking: social and economic disorganization of low-income communities; the absence of existing community models for the delivery of comprehensive services; the limitations of community human service resources; the absence of integrated service delivery networks; the number, level, and comprehensiveness of services to be provided; the extensive multifaceted needs of program families; and cultural attitudes concerning human services programs. To provide information relevant to future policy and programs, the Administration on Children, Youth and Families (ACYF) chose to carefully study the feasibility of CCDP implementation and to analyze the processes and costs of ongoing activities. That is, ACYF chose to examine (1) whether and how these programs can be implemented successfully to meet the goals of the program and the needs of the families, (2) whether these family and program goals were achieved, and (3) the cost of operating a CCDP project.

Although local CCDP projects use varying service delivery systems and services integration arrangements to provide services, all CCDP projects have the following common goals:

- To enhance family development and stability through family empowerment;
- To enable economic and social self-sufficiency; and
- To optimize early childhood development.

These goals frame the following overarching research question for a feasibility analysis and process evaluation of CCDP: How and to what degree are services made available and utilized (1) to address family needs and goals and (2) to promote positive family development? To answer this question, one must have an understanding of the development of CCDP projects and the means and costs of service provision and use within and across sites to meet family needs. This focus involves both (1) discerning the contingencies that affect the feasibility of developing a coordinated, family-based service program and (2) identifying and studying those contingencies in addition to the family characteristics and needs that affect service utilization and goal attainment.

The issue of feasibility concerns the success of implementing a coordinated service system at the local level that makes comprehensive human services available and accessible to families, without incurring excessive costs. The issue is to ascertain if it is possible to establish a CCDP project as originally intended. In order to answer this question, one must study the issues surrounding program startup, such as the community and organizational settings, resources and support of the grantee agency, and the characteristics and natures of the populations residing in those communities.

The main issue addressed by the process evaluation concerns the provision and use of services within the service delivery system and program established by a local CCDP project. The process evaluation seeks to answer such questions as the following:

- How are services actually provided and utilized?
- Are family and individual goals met?
- What are the factors that affect service utilization and goal attainment?
- How satisfied are families with CCDP?
- How has CCDP impacted the community?
- What factors are related to project attrition?
- How much does it cost to operate a stabilized and fully functioning CCDP project?

An overview of the conceptual model to be used as the framework for conducting the feasibility analysis and process evaluations follows, as well as a discussion of which components of this model will be presented in this interim report.

CONCEPTUAL MODEL

The foundation for the CCDP feasibility analysis and process evaluation conceptual model is Bronfenbrenner's (1979) ecological theory of human development. The two main aspects of an ecological theory of family support and child development intervention are as follows:

- Incorporation and utilization of inputs from a system that consolidates feedback among several levels of organization (e.g., individual, family, project, community, and culture); and
- The assumption that change processes are an inherent component of each level of the system (Dym, 1988).

As such, the design of an ecologically based program should account for context, connection, stability, and change at each level of the system. As discussed below, the design of the conceptual model for the CCDP feasibility assessment and process evaluation explicitly incorporates these concepts.

The feasibility analysis and process evaluation models presented in the *CCDP First Annual Report* (CSR, 1991) provided the groundwork for the development of a revised conceptual model. These earlier models were somewhat limited in their ability to adequately capture factors associated with variations in the CCDP projects' feasibility and processes. First, the models were static, meaning they failed to allow for changes in communities, projects, and families over time. Second, community context was defined narrowly as a set of exogenous input variables affecting service utilization.

In the revised and expanded conceptual model illustrated in Exhibit 3-1 following the next page, CCDP projects go through a series of chronological organization lifecycles. Also, connections among components of the model are conceived as primarily comprising bidirectional (versus unidirectional) cause-and-effect relationships. Finally, the community context is conceptualized as a broad set of multilayered distal and proximal variables that affect, and are affected by, both the feasibility and operational processes of CCDP projects. Because the revised conceptual model in Exhibit 3-1 includes community context as a core component influencing, and being influenced by, both feasibility and process model components, a discussion of community context is presented first, followed by a discussion of the concept of stability and change. This is followed by a discussion of the feasibility analysis and process evaluation models.

Community Context

In keeping with an ecological framework, community context plays a critical role in the feasibility of CCDP projects. Community context includes the social, economic, political, and cultural factors and characteristics that make up the local environment in which a CCDP project operates. More specifically, community context includes the following:

- Socioeconomic characteristics of the community (e.g., the availability of housing and jobs) and the relative position of the community regarding these characteristics within a larger context (e.g., city, State, and the Nation);
- The degree of social disorganization and problems in the community (e.g., alcohol and other drug abuse, teenage pregnancy, and racial tensions) and the community's relative position within the larger context; and

- Attitudes and perceptions of local public and private agencies regarding a CCDP project, its grantee agency, and the philosophy of CCDP prior to and subsequent to the implementation of that CCDP project.

The community context plays a major role in the feasibility of implementing and operating a CCDP project. For example, the resources available in the community affect a CCDP project's ability to build a coordinated service system for CCDP families. Other community resources, such as available housing, public transportation, and employment opportunities also may affect the structure of CCDP and patterns of service utilization. The community context may affect the CCDP model through the existence or nonexistence of social support and belief systems that encourage and facilitate services utilization and project participation. For example, community values that support higher education and discourage dependence on Government support may affect families' use of and participation in CCDP. The community's characteristics, such as urban or rural nature, crime level, prevalence of drug use, and poverty level, also may affect the specific delivery characteristics of the CCDP model. Community context thus acts both as a structural framework within which project-family interactions develop and as an external source of "inputs" (e.g., barriers and facilitators) to the project processes that have an impact on the feasibility of implementing a CCDP project.

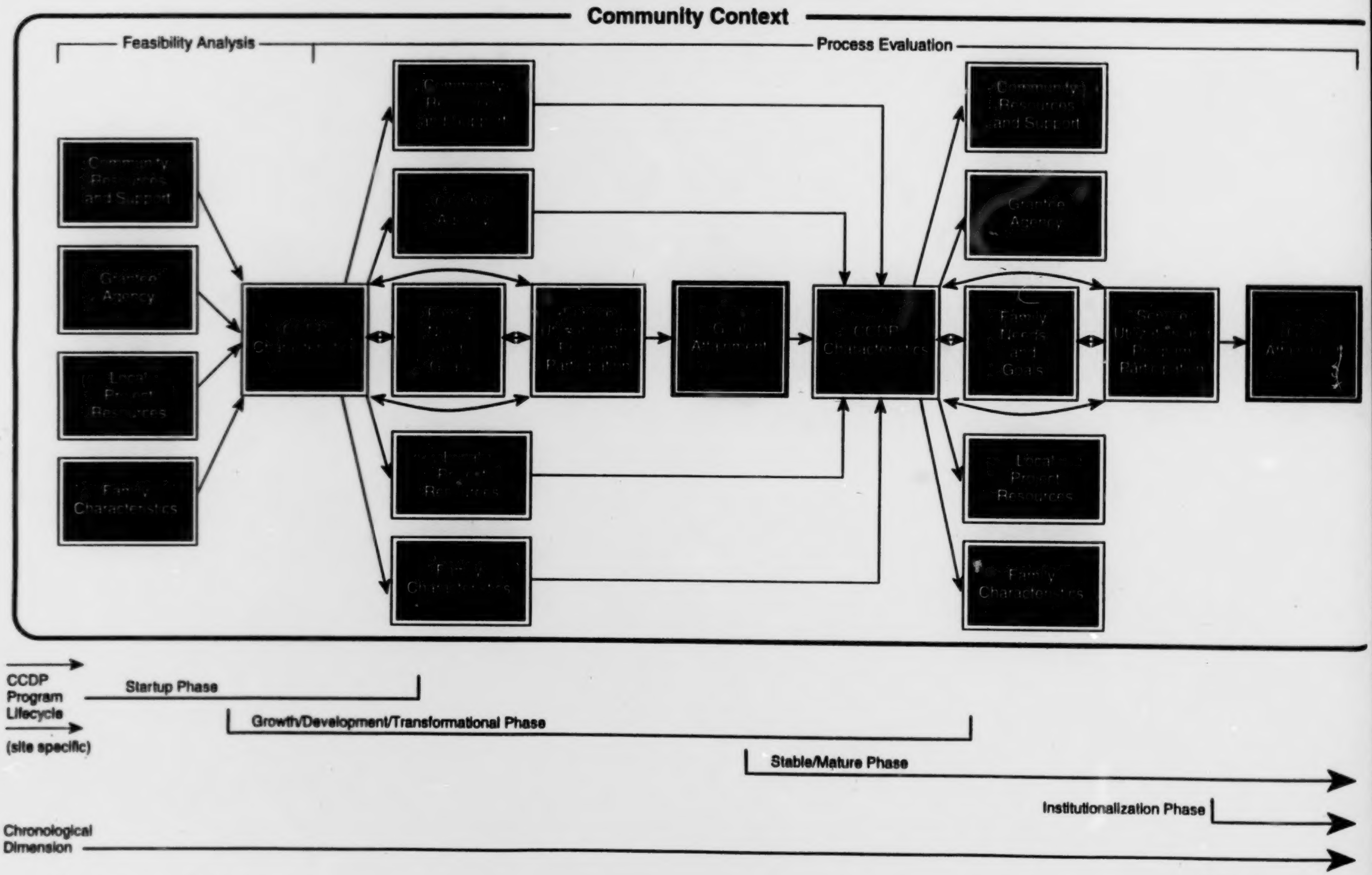
Community context is envisioned as impacting both human and organizational developmental processes at each stage of individual or project development. For example, socioeconomic characteristics of a community affect the nature of families' needs and goals and influence each CCDP project's ability to provide quality services based on local project resources, community resources, and support. As the socioeconomic characteristics of a community change over time, families and CCDP projects must adjust accordingly. For example, if a community loses a major industry, individuals who worked in that industry are faced with finding other employment. As a result, CCDP projects may need to change the focus of their adult vocational/technical and educational programs to help laid-off workers make the transition to another line of work. These changes made by families and projects may, in turn, lead to an improved economic base. For example, when a manufacturing-based economy is replaced by a service-based economy, workers may begin to think about alternative future employment opportunities, and CCDP may decide to focus on retraining adults for service versus manufacturing jobs. The combination of these factors may result in the establishment of a local source of service industry workers.

Stability and Change

The concept of a lifecycle is particularly useful in describing the development of CCDP projects. As shown in Exhibit 3-1, CCDP projects can be conceived as attaining different phases of the lifecycle at different rates. At the programmatic level, the conceptual model incorporates the following

Exhibit 3-1

CCDP Feasibility Analysis and Process Evaluation Conceptual Model


Community Context
Feasibility Analysis
Process Evaluation
Community Resources and Support
Grantee Agency
Local Project Resources
Family Characteristics
Characteristics
Attainment
CCDP Characteristics
Community Resources and Support
Grantee Agency
Family Needs and Goals
Program Participation
Local Project Resources
Family Characteristics
CCDP Program Lifecycle (site specific)
Startup Phase
Growth/Development/Transformational Phase
Stable/Mature Phase
Institutionalization Phase
Chronological Dimension

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four basic lifecycle phases: (1) the startup phase; (2) the growth, development, or transformational phase; (3) the stable/mature phase; and (4) the institutionalization phase. Chapter 4 presents a preliminary analysis of the projects' progressions through these phases.

Feasibility Analysis

The first part of the CCDP-revised conceptual model presented in Exhibit 3-1 comprises four general components hypothesized to affect the development and characteristics of a CCDP project (see left side of Exhibit 3-1). This portion of the model addresses the feasibility of "setting up a coordinated system at the local level that makes comprehensive human services available and accessible to families" (CSR, 1991, p. 13). A description of the four feasibility components of the model—(1) community resources and support, (2) the grantee agency, (3) local project resources, and (4) family characteristics—that affect a project's development during the startup phase follows. The specific variables associated with each of these components are presented in Exhibit 3-2 following the next page.

Community Resources and Support

A major feature of a coordinated service system for CCDP families is the development of cooperative arrangements between the CCDP project and other service agencies as well as the strength and duration of community agency support for CCDP. Thus, the feasibility analysis also concerns the availability and quality of other services in the community and the response of public and other community agencies to the local CCDP project and its mission. For example, in communities that have access to a relatively large number of high-quality services, CCDP projects can focus more on integrating services, as opposed to focusing on identifying or developing services in resource-poor communities.

The history of interagency cooperation and service integration which existed in the community prior to CCDP implementation also influences program development and characteristics. For example, in communities where the coordination of agency efforts has been neglected, CCDP projects' efforts to take a lead role in services integration may be welcomed or perhaps viewed as interfering with the existing system. How well CCDP is received will be related to the skills and sensitivities that CCDP staff bring to the effort of integrating services. For example, in communities where past services integration efforts have failed, the CCDP staff's efforts to integrate services may be viewed as intrusive or redundant.

Finally, different community attributes (e.g., crime and poverty levels) affect the feasibility of implementing CCDP projects in rural versus urban settings. For example, urban communities typically are plagued by a greater number of risk factors than rural communities. Therefore, in urban CCDP projects, case managers and other line staff often have experienced difficulties progressing beyond the management of families' crises. On the other hand, the lack of transportation tends to be a more salient problem in rural areas than in urban areas. Thus, rural CCDP projects typically spend a large percentage of their budgets on transportation services. In both examples, the feasibility of implementing a CCDP project is influenced by attributes of the community.

Grantee Agency

Different types of grantee agencies may influence project development in different ways. First, the type of grantee agency can determine which services the CCDP project will provide and which will be provided through referral and cooperative arrangements. For example, coordinating health services for CCDP families may be less of an issue in program development for a grantee that is a major community health agency.[1]

The type of agency also may affect staff recruitment and development requirements. For instance, a family services agency, with a history of providing community outreach and case management services, may have fewer staff development requirements or problems in implementing a case management model. In turn, CCDP projects that spend less effort and fewer resources training staff should find fewer barriers to implementing a system of comprehensive services.

Another important factor affecting the feasibility of implementing a CCDP project is the stature and leadership role of the grantee agency in the community. For example, it is expected that attempts to establish formal interagency agreements would be facilitated by a grantee agency that already has a major leadership position in the community services network. Grantee agencies that provide strong leadership also provide a model for CCDP management staff.

Local Project Resources

Local project resources, which include factors such as the availability and adequacy of office space, qualified staff, staffing levels, funding streams, services, materials, and transportation, as well as management organization and strengths, also can affect CCDP projects. A project's ability to serve families effectively can be affected greatly by the administrative characteristics of both the project and its parent agency. For example, inadequate office space, too few staff to serve families effectively, or even an agency's lack of experience in administering a large Federal grant relate directly to the feasibility of project implementation.

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[1] This suggests that the feasibility of implementing a CCDP project should be analyzed in terms of implementing specific components of a CCDP project in addition to the overall implementation feasibility.

Exhibit 3-2

CCDP Feasibility Analysis and Process Evaluation Variables in the Conceptual Model

COMMUNITY CONTEXT

INPUT VARIABLES

Community Resources and Support

- Availability of services
- Quality of services
- Interagency cooperation and integration
- Response of community agencies to CCDP
- Funding streams

Grantee Organization

- Type of organization
- Funding
- Stature and leadership role in community
- Length of tenure in community
- Support for CCDP
- How CCDP fits into grantee organization
- Funding, materials, and supplies
- Prehistory: why applied for grant

CCDP Local Project Resources

- Qualified staff available in community
- Funds
- Infrastructure
- Transportation

Family Characteristics

- Sociodemographics
- Family composition
- Problems/needs/goals
- Attitudes toward service system
- Cultural values regarding family, employment, etc.

CCDP Characteristics

- Philosophical approach
- Organizational framework
- Delivery system
- Staff quality
- Management quality
- Staff training
- Case management models
- Core services
- Quality of core services
- Availability of other services
- Project activities
- Educational models and curricula
- Interagency agreements
- History of relationships with other agencies
- Advisory board (commitment, involvement)
- Parent councils (commitment, involvement)
- Project stability
- Compliance history

Family Needs and Goals Established

- Types of needs established
- Number of needs established
- Patterns of needs established
- Types of goals established
- Number of goals established
- Patterns of goals established
- Method and intensity of addressing needs/goals

Service Utilization and Project Participation

- Type, frequency, and patterns of services utilized
- Goodness-of-fit between problems/needs, goals, and services utilized
- Type, frequency, and patterns of participation in project activities

OUTCOME VARIABLES

Goal Attainment

- Types of goals attained
- Number of goals attained
- Effort
- Progress

Needs

- Types of needs addressed
- Number of needs addressed

Attrition

- Patterns of attrition
- Reasons for termination
  - positive
  - negative
  - neutral
  - inactive

Effect on Community

- Community services availability and access
- Parent involvement and leadership in community

Costs

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Family Characteristics

Characteristics of CCDP families—including demographic characteristics, the level and extent of the families' needs, the families' cultural values, and the families' attitudes toward the program and the wider community service system—can influence both the structural and operational components that compose the CCDP model. Families with different educational levels may exhibit different ability levels and/or willingnesses to participate in CCDP activities. Variations in participation levels in turn will influence the level and intensity of services provided by program staff. For example, compared to families motivated to participate in CCDP services or activities, families that resist participation in CCDP require a greater effort on the part of the program staff in motivating them to participate.

Changes in Feasibility Components

In addition to providing inputs into the development of the CCDP projects, the feasibility components discussed above are depicted in Exhibit 3-1 as possibly changing over time due to the development and maturation of the CCDP project. Examples of this feedback loop between each of the feasibility components and CCDP projects are provided below.

The availability and quality of community human services will play a major role in the characteristics and structure of particular CCDP projects. For example, in communities where there is a significant lack of available quality child care services, CCDP projects may need to expend a significant amount of their resources and time developing these services, with the likely result that additional community child care services will be made available.

CCDP grantee agencies that have heretofore played minor roles in their local service network systems may view the implementation of CCDP projects as an opportunity to increase their own visibility and stature in the community. By providing strong administrative and financial support to a CCDP project's efforts to strengthen services integration in the community, a grantee agency can play a major role in reshaping a project's functional character.

Finally, cultural, attitudinal, and behavioral characteristics, as well as the needs and goals of CCDP-eligible families, have an influence on the nature of a CCDP project throughout its lifecycle. In communities where many families have exhibited generally negative attitudes about traditional social service agencies, CCDP, through its emphasis on empowerment, could affect changes in families' attitudes about participating in social services. Furthermore, CCDP projects focus on making families believe in themselves and their potential for growth. These efforts could shift family priorities from deficit reduction to empowerment goals. For example, in communities where housing is a particularly salient problem, CCDP projects strive first to satisfy the need for affordable, quality housing, thus allowing families to focus more of their efforts on empowerment activities such as job training and/or educational advancement.

Process Evaluation

The process evaluation segment of the conceptual model contains the following three additional components: (1) the CCDP characteristics, (2) family needs and goals, and (3) service utilization and program participation (see Exhibit 3-1). A description of these components follows. The specific variables associated with each of these components are presented in Exhibit 3-2.

CCDP Characteristics

CCDP characteristics encompass the following: quality and availability of services provided; delivery system used; staff, organizational structure, facilities, philosophical approach, and curricula used; and interrelationships with cooperating agencies. CCDP models are influenced by the four feasibility variables and affect services utilization and goal attainment; therefore, CCDP characteristics are components of both the feasibility and process evaluation models.[2] The question for service utilization is whether, or how, program operations facilitate service use by families. For example, there are concerns over whether differences in the service delivery systems across projects are related to differences in the frequency and intensity of services utilization. Also of interest are common attributes in the service systems across projects that facilitate or impede efforts to address family needs and goals.

Family Needs and Goals

A common goal of CCDP is that services are provided and utilized to address family needs and goals. This goal suggests two analytical issues: (1) the types and extent of family needs within and across CCDP projects and how they relate to actual service use and (2) the degree to which families attain their goals. The degree and intensity of services that are developed or made available to meet family needs also will be examined.

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[2] Which component the CCDP project belongs to depends on the focus of the analysis at hand. In analyses focused on startup processes and feasibility issues, the CCDP project is treated as a set of dependent variables in the feasibility analysis. In analyses considering project processes as they change over time, the CCDP project is treated alternatively either as an independent variable (affecting changes in families and the community) or as a dependent variable (being affected directly or indirectly by family problems, needs, and goals established; service utilization and project participation; community resources and support; the grantee agency; local project resources; family characteristics; and the community context).

Service Utilization and Project Participation

Families vary according to the types, frequency, and patterns of their services utilization and participation in CCDP. This variation is in large part a function of the types of needs, problems, and goals identified and established as part of the case management process. Also, service utilization patterns can be described as the degree to which there is a "goodness of fit" between established needs and goals, the characteristics and quality of the CCDP project, and the quality of available services. Service utilization patterns will be described in this interim report in terms of frequencies and the average number of services utilized in the first half of Fiscal Year 1993.

In this interim report to Congress, as well as in the final report to Congress, the study of service utilization and goal attainment will encompass both quantitative and qualitative analyses. However, in this interim report the focus will be on examining factors within each component of the model, whereas in the final report the focus will be on examining interrelationships between components.

Process Outcome Variables

Process outcome variables are defined as those family, project, or community outcomes associated with the processes of implementing, operating, and adapting the CCDP model relative to the needs and goals of families. Examples of variables reflecting project processes are case management (family level), staff training (project level), and interagency agreements (community level). Although there is differentiation among these three levels of project processes, in reality they overlap in their influence on outcomes. For example, identification of needs and goals is mainly a function of the case management process (family level). However, the availability and accessibility of services used by the family to attain its goals is partly a function of the number and types of interagency agreements (community level). Furthermore, the type and intensity of case management training also will be related to the success of identifying and accessing appropriate services (project level).

Other Outcomes: Attrition and Costs

In addition to the process outcomes discussed above, an analysis of two additional outcomes—attrition (terminations) and costs—are included in this interim report (see Chapters 5 and 8, respectively). Questions regarding these outcomes will address both the feasibility of CCDP and the nature (i.e., the how and why) of project processes. For example, examinations of attrition patterns and reasons for terminations could shed light on the quality of certain service component models for encouraging project participation and enrollment. Likewise, an examination of cost patterns could address such issues as which program and community variables affect CCDP expenses and whether variations in costs are related to variations in process outcomes.

For the sake of visual simplicity, and because analyses of attrition and costs are envisioned as addressing questions about both the feasibility and processes of CCDP, these outcomes are not included in Exhibit 3-1. However, in Exhibit 3-2—in which specific variables associated with each of the model's components are presented—these outcomes are included on the right-hand side.

Data Sources for the Feasibility Analysis and Process Evaluation

The CCDP projects' proposals, budgets, and quarterly progress reports provide information on the formal structure of the service network (e.g., interagency agreements and services provided by the CCDP project), the progress and changes in program development and management (e.g., staff hiring, personnel functions, and family recruitment), and costs. Ethnographers' reports provide more detailed data on the process of program implementation, providing descriptions and insights on how community resources and supports, grantee agency attributes, local project resources, and family characteristics and behavior facilitate or impede program implementation. In short, the ethnographers' reports provide data on the dynamics and natural history of the implementation and ongoing operation of the local CCDP projects. Site visits provide data on the status of program development in terms of the design and intent of the national CCDP demonstration program. The management information system (MIS) provides more quantitative data on families and service descriptions relevant to feasibility questions.

Management Information System

The MIS was developed (1) to provide part of the data used to respond to congressionally mandated data requirements as specified in Public Law 100-297 and (2) to answer a series of management analysis questions (see Exhibit 3-3 on the following page). The need for these data was stated in the December 29, 1988, *Federal Register*, and in a supplement to this announcement that stated that grantees would be required to use an MIS. The MIS was to record data on families, programs, staff, the programs' collaborative arrangements, ongoing services, and costs. The developmental process for the MIS was a thorough one, involving grantee input from the beginning. MIS forms were revised extensively to accommodate the grantees' comments and concerns about form content, the feasibility of obtaining the information, the burden involved in form completion, and the information that would be useful to grantees for their own purposes. Field tests of the MIS data collection forms were conducted at four sites. The field tests resulted in an improvement in the precision and utility of the forms and data definitions. Because the MIS collects individual data on program participants, the system had to be approved by the U.S. Office of

Exhibit 3-3

Management Analysis Questions (Used To Design the CCDP Management Information System)

1. What planning strategies are being used in implementing a CCDP model? How much time is needed for a program to become fully operational? How much time is needed to achieve stability in providing core services to enrolled families?

2. What are the characteristics of the various coordination/collaboration arrangements used by grantees? How are CCDP's linked with other service providers? Is there duplication of services? What is the relationship between available services and the proximity of enrolled families?

3. What are the characteristics of enrolled families? How do these families compare with the characteristics of poverty families in the community?

4. Which non-CCDP-sponsored services are enrolled children and families receiving? Which CCDP-sponsored services (health, social, educational, and child care) are enrolled children and families receiving? Are they receiving all the core services required by this program? Describe the duration and frequency of such services by type. Are these services compatible to the different assessed needs and special needs of children and parents? How are the needs of enrolled families being assessed?

5. Which educational models are being used? Are children receiving educational activities that are developmentally appropriate? Describe classroom and staff characteristics.

6. Describe the characteristics of program models, service delivery systems, and coordination arrangements over time.

7. Describe the extent of parent participation in the program and the degree and type of activity. Does this activity vary by characteristics of the family, such as socioeconomic status, number of children, ages of children, and family structure? Does it vary by characteristics of the program? Describe the extent to which families are achieving goals and the amount of progress they are making.

8. Describe whether services are consistent with acceptable Federal, State, or local standards, including Head Start Performance Standards.

9. Describe the costs (CCDP money and non-CCDP money) of providing services by category, family, family member, program model, and auspice. Compare with the costs that other service families would be (or still are) receiving. How do these costs vary as a function of the specific coordination/collaboration arrangement?

10. What is the attrition rate of enrolled families? Does it vary by family characteristics? Why do families leave?

11. What are the characteristics of replacement families? How do they compare with families they replace?

12. What are the barriers that the projects experienced in program implementation?

Management and Budget. The MIS was submitted for approval in June 1990, and unconditional approval was received on April 26, 1991.

Data are recorded in the MIS on the program, family, and individual family member levels, and all services received by family members are documented in the system. A sequential format enables the assessment of family needs, the service plan, goal attainment, and utilization of the services to assist in meeting goals. The information modules contained in the system are listed in the table below.

MIS INFORMATION MODULES	
Project profile	Adult educational/vocational course attendance
Project budget	Child educational program description
Quarterly expenditures	Home visiting program description
Services location profile • Services • Staff • Licensed facility description	Child educational program attendance
Area demographics	Family services contact summary
Recruitment	Health/(re)habilitative services
Family profile	Pregnancy description
Volunteer participation	Birth record
Adult educational/vocational program description	Death record
Adult educational/vocational course description	

MIS data are used for the quantitative analysis of family characteristics; family problems, needs, and goals; service utilization; volunteer participation; and CCDP costs. MIS data related to each of these areas are as follow:

- *Family characteristics.*—The major form in the MIS for family characteristics is the Family Profile Form. This form includes sociodemographic information on families and individual family members. It also includes information regarding reasons for terminations from CCDP.

- *Family problems, needs, and goals.*—The major form in the MIS for both family and individual family member needs and goals is the Family Assessment Form. The services planned to address family goals are recorded on this form.

- *Service utilization.*—A record of services received is included on the following forms: Services Contact Summary, Adult Educational/ Vocational Course Attendance, Child Care/Educational Program Attendance, Home Visiting Program Description, and Health/(Re)habilitative Services.

- *Volunteer participation.*—Data from the MIS Volunteer Participation Form were utilized to document activities of both CCDP participants and community volunteers.

- *CCDP costs.*—The main source of data for the cost analysis is the projects' budgets. This data source is supplemented by data from the MIS project budget and quarterly expenditure forms. In the final report, data for the cost analysis will come from the MIS and time allocation studies. The MIS will contain the unit costs for services provided through some interagency contracts and agreements. Time allocation studies will determine the CCDP staff costs for different service areas. The cost analysis will identify variations in costs associated with different project arrangements for coordinating and providing services.

Cost Analysis System

The preliminary cost analysis presented in this report is based on data extracted from the Year 3 operating budgets (i.e., the second year serving families). For the final report, cost information will be used to describe the cost allocations by program, component, and family member and will have input into the cost analyses. Data for the cost analysis for the final report will be drawn from (1) the MIS and (2) time allocation studies in which project staff members maintain records of the time they spend on various activities, including service provision. The MIS contains project budget information, quarterly expenditures, definitions of service units, and the unit costs for services provided through interagency agreements and contracts. The implementation of time allocation studies will identify CCDP staff costs for different service areas. The cost analysis system will identify service costs by recipient and variations in costs associated with different project arrangements for coordinating and providing services.

Ethnographer Reports

One of the main sources of qualitative data for addressing issues regarding project development, service provision, and utilization are the reports from project ethnographers. While the MIS data help explain the numbers and demographic characteristics of participating families, they do not explain why some families participate more extensively than others or what factors facilitate or impede family utilization of services. The CCDP ethnographic research is most valuable in revealing unexpected, complex, intangible, and subtle factors that explain family utilization and program feasibility as well as services integration and community impact.

During the first year of the CCDP project, each of the sites hired a part-time ethnographer. Most of the ethnographers are trained case study researchers who hold doctorate degrees in the social sciences.

The first step ACYF undertook in implementing the ethnographic component was to develop a framework and guidelines for use by the ethnographers. These documents were crucial in providing a standardized format and common structure, so that the information contained in case studies conducted at the CCDP sites could be compared and analyzed around common themes. The framework and initial guidelines were developed after intense discussions with the ethnographers at the May 1990 conference, providing an opportunity for the study design to benefit from their combined wisdom and early experiences in the field. A subsequent CCDP grantee conference also included the participation of the ethnographers, which allowed their further input in guideline development.

The framework was intended to provide an overall conceptual model for the ethnographers' efforts (see *CCDP First Annual Report* [CSR, 1991] for more details). Consequently, the framework presented an ecological perspective focusing on the following four domains: (1) the community, (2) the community service network, (3) CCDP program/service delivery, and (4) the family. Under each domain, relevant questions and issues pertaining to factors involved in program feasibility and family utilization were listed. It was not expected that any one of the ethnographers' reports would cover all of the questions listed in the framework. Rather, priority topics and selected questions from the framework are identified in the guidelines for each of the reports. The topics for the first eight ethnographers' reports are listed in Exhibit 3-4 following the next page.

In preparing these reports, the ethnographers used a variety of information sources, such as interviews with parents, CCDP staff, or community agency staff; written documents; and observations of advisory board meetings or CCDP service provision. To ensure that the ethnographers' reports remained focused, a 25- to 30-page limit was suggested. In addition to the major topics in the guidelines, each report was required to include an introduction, summary, and methodology section.

Site-Based Data

Three-day site visits to each grantee are conducted at least once per year. The site visit team comprises ACYF's Federal Project Officer or designee and staff from the management support contractor. The purposes of these visits are (1) to monitor program compliance, (2) to provide technical assistance on programmatic and MIS issues, and (3) to collect data for the feasibility analysis and process evaluation.

Quarterly Progress Reports

The CCDP grantees submit to ACYF and CSR four quarterly progress reports (QPR's) per year. In these reports, the projects describe their progress in completing the activities that address the "Areas Needing Improvement" and still outstanding "Noncompliance Areas" cited in their action plans. In addition, the QPR's describe significant activities, accomplishments, and problems for the topics listed in the table below.

PROGRESS REPORT TOPICS	
Recruitment/replacement	Adult education/vocational training
Case management	Job placement
Child care	Programs for males
Health care	Data management
Child developmental assessment	Advisory board activities
Early childhood education	Staff hiring, turnover, and training
Early intervention	Interagency relationships
Parent education/support	Other activities/accomplishments

QPR's alert ACYF and CSR to any technical assistance that would be helpful to the CCDP projects, describe dissemination activities undertaken by the grantees, and note activities planned for the next reporting period.

The QPR's also are used by ACYF and CSR (1) to monitor the progress of projects in adhering to CCDP requirements based on annual site visits and (2) as a source of qualitative data for the feasibility analysis and process evaluation.

Summary of the Feasibility Analysis and Process Evaluation Models

The overall purpose of the feasibility analysis and process evaluation is to provide information that will be useful for policy on future program enactment and design. The assessment of feasibility and program operations can assist in making judgments about initial program success. This interim report presents preliminary analyses of program implementation and program impact on families and the community. The final report will include an overall evaluation, providing greater understanding of the processes occurring within and across sites to identify any program design modifications that might lead to further benefits if implemented on a broader scale.

The conceptual framework presented in this chapter provides the basis for designing the preliminary analyses presented in this report and will provide the basis for the design of analyses for the final report.

Exhibit 3-4

Topics for Ethnographers' Reports

Report	Topics
One	Planning/Startup Activities Program Goals/Systems and Organization Contextual Issues (e.g., social, economic, and political issues of the community)
Two	Continued Planning/Startup Activities Service Network CCDP Service Model/System Family Response
Three	Emerging Project Issues Emerging Contextual Issues Health Services (e.g., for pregnant women, mothers, children, and other family members) Child Care Availability/Accessibility Specific Changes (e.g., community agencies' attitudes toward CCDP, case manager's role, and advisory board meeting attendance/participation)
Four	Emerging Project Issues Emerging Contextual Issues Parent Education (e.g., home and center based) Employment/Training Specific Changes
Five	Emerging Project Issues Emerging Contextual Issues Assistance in Securing Adequate Housing Family Member Satisfaction

Exhibit 3-4 *(continued)*

Report	Topics
Six	Emerging Project Issues Emerging Contextual Issues Barriers to Services Integration
Seven	Emerging Project Issues Emerging Contextual Issues CCDP Organizational Lifecycle
Eight	Emerging Project Issues Emerging Contextual Issues Family Attrition

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Chapter 4. PROJECTS' LIFECYCLES

The degree of efficacy and efficiency with which a project is able to fulfill its goals at any single point in time may be regarded as a function of organizational development. Therefore, any evaluation of the success of the Comprehensive Child Development Program (CCDP) (either in terms of feasibility, family successes, or organizational success) must consider variations in CCDP projects' progress through organizational lifecycles. The concept of a lifecycle for CCDP was first discussed in Chapter 3 of this report. Lifecycles are particularly useful in describing the evolution of organizations (Fottler and Smith, 1988). CCDP projects pass through a series of predictable organizational cycles or phases, with individual projects passing through different phases at different rates. The phase that a project is in and the rate at which a project passes through each phase may be related to a variety of factors, including the strength, stability, and experience of the grantee agency; characteristics of the community (e.g., urban or rural location, quality and availability of transportation, and degree of support from community organizations); characteristics of the project (e.g., costs, the quality of management plans and activities, and staff turnover); and characteristics of CCDP families (e.g., types of needs, race/ethnicity, and family size). Because this interim report covers only the early and middle stages of CCDP projects' operations, the evolution of CCDP projects is not yet complete. In the final report, an analysis of the complete lifecycle of individual projects will be presented, along with implications for interpreting their successes.

The information used to prepare this section is derived from the Ethnographer's Report No. 7. CCDP ethnographers were asked to describe the organizational lifecycle or "natural history" of the CCDP projects from their inception in October 1989 through September 1992 (3 years of operation). Using interviews with project staff, examinations of project records, and observations, ethnographers were to provide descriptions of their CCDP projects' developments through four organizational phases: (1) startup, (2) growth, (3) stabilization, and (4) institutionalization.[1]

The characteristics of an organization in each phase are as follows:

- *Startup*.—This phase includes the early development of an organizational structure, identification of the goals and philosophy of the program, a sense of innovation among the project staff, the genesis of a project identity, and the assembly of organizational and community resources.

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[1] In the final year, ethnographers will be asked to reevaluate the life history of the CCDP projects over their entire 6 years of operation (October 1989 through September 1995).

- *Growth.*—This phase is marked by movement toward a centralized organization; a definitive statement of the goals and philosophy of the program; the provision of a core set of services to all families; the development and testing of project policies and procedures; significant progress toward procuring necessary resources, staff, and finances; and beginnings of functional linkages with community and public agencies and organizations.

- *Stabilization.*—This phase is evidenced by functional organizational procedures, policies, and goals; staff who generally conform to established policies and procedures; a range core and noncore services that meet the needs of the target population; ongoing and established working relationships with outside agencies; and attention to the quality components of the project.

- *Institutionalization.*—This phase is characterized by the solidification of organizational procedures, policies, and goals and a high degree of centralization and bureaucratization. During this phase, a project may become adaptable to changing client needs and local circumstances by developing long-range plans, new units within the organization that are designed in response to changing family needs and goals, or new resources (e.g., interagency agreements and staff training in areas such as recognition of alcohol and other drug problems) that deal specifically with changing circumstances. On the other hand, a project also could become rigid and inflexible and unable to respond effectively to changing client needs.

The findings presented in the next section include the results of a content analysis of the ethnographers' responses to the following:

> ...describe the evolution of your project. In your description, summarize its passage through the various phases of the organizational lifecycle and where you think it is now in the cycle, giving approximate timeframes and your data sources.

In the last section of this chapter, the results of a content analysis of ethnographers' responses to the following question are presented:

> Have there been major changes in the goals and philosophy of your project or in their emphasis since the program's inception? Describe these changes and the rationale for these changes.

Please note that in the rest of this report, the names of the projects have been replaced with letters to protect their identities.

LIFECYCLE ANALYSIS

The second column in Exhibit 4-1 following the next page presents the lifecycle phase of 20 CCDP projects as of September 1992.[2] One (urban) project was still in the growth phase, while 10 (5 rural and 5 urban) had reached the stabilization phase. The remaining nine (one rural and eight urban) had achieved or virtually achieved institutionalization.

Only seven projects (three stabilized, three institutionalized, and one in the growth phase) had passed through more than one startup phase since inception. This suggests that most projects progressed through that phase without difficulty. As expected, the one project classified as still being in the growth phase experienced a series of startups in which program goals or philosophies changed several times. However, only one of three stabilized projects and one of three institutionalized projects that had gone through more than one startup also changed their program philosophies.

It is interesting, although predictable, to note that two-thirds (six of nine) of the projects classified as achieving institutionalization had never changed their program goals or philosophies since inception. This compares with two-fifths (4 of 10) of the projects that had only reached the stabilization phase (this finding is discussed later in this chapter). Another related difference between projects that achieved stabilization and projects that achieved institutionalization was that almost all of the stabilized projects had made changes in organizational and management policies (90 percent), whereas somewhat fewer institutionalized projects made such changes (67 percent).

Finally, approximately the same percentage of stabilized (60 percent) and institutionalized (56 percent) projects had made changes in their staff structure and qualifications.

Presented first is a summary by the ethnographer for the project rated as having only achieved the growth phase. This is followed by an ethnographic summary analysis of a sample of projects having achieved stabilization or institutionalization.[3]

Growth Phase and Transition to Stabilization

Project C, classified as being in the growth phase as of September 1992, is located in a major urban area characterized by great poverty and social disorganization. The problems that were faced implementing this CCDP project largely can be traced directly or indirectly to characteristics of the community. For example, the ethnographer reported that "It was difficult to fill key staff positions and consistently hire the most capable staff, because the project's location and target population appeared to 'frighten off' many good applicants...." Furthermore, because of its location in a high-density population neighborhood, the project experienced many difficulties "obtaining suitable office and day care space." The difficulties this project faced becoming stabilized also can be traced to recurring management problems. For example, the ethnographer reported that, during the early stages of the project, there was "too much emphasis on the needs and interests of staff and use of complex and cumbersome management structures rather than an adaptation of the simple structure favored by Fottler and Smith (1988)."

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[2] The ethnographer report for one project was not completed at the time this report was prepared.

[3] Most projects categorized as being institutionalized were described as having some components in the stabilization phase, some in the institutionalization phase, and others in transition from one phase to another.

Furthermore, the project failed to build an effective collaborative network early on with other community agencies that serve low-income families. As a result,

> ...although the project manager believed that the project could become the focal point for areawide collaborative activity, this never occurred, and the project failed to carve a niche for itself in the larger social services community.

Another impediment to the project's successful transition from the startup phase had to do with the fact that many families who enrolled in this CCDP project experienced frequent crises; the project's staff "...continually operated in a crisis mode and tended to focus on short- versus long-term goals."

While other projects faced similar problems, this project appeared to be unique in that it faced all of these problems simultaneously during the critical startup phase.

Stabilization and Transition to Institutionalization

Below are described several projects that were making the transition from stabilization to institutionalization or had achieved institutionalization.

Project G was identified as beginning the transition from stabilization to institutionalization. According to the ethnographer, this judgment was based on his finding that few major changes had taken place in the project since it had become stabilized. While this project made a relatively smooth transition through the startup, growth, and stabilization phases, after stabilization was achieved, very few changes occurred in the project's goals, philosophy, policies, procedures, and model. For example, the ethnographer notes that, since stabilization was achieved, "the service delivery model has not changed significantly in the past year." The ethnographer also noted that "there has been no official change to the philosophy and goals of Project G; there have been no major changes in the policies, procedures, or means of communication."

Exhibit 4-1

CCDP Organizational Phases

Project*	Current Phase (as of September 1992)	Passed Through More Than One Startup Phase	Changes to Program Goals and Philosophy
C	Growth	Yes	No
K	Stabilization	Yes	No
R*	Stabilization	Yes	No
W*	Stabilization	No	Yes
M	Stabilization	No	Yes
I	Stabilization	No	Yes
S*	Stabilization	No	Yes
E*	Stabilization	No	Yes
J	Stabilization	Yes	Yes
D	Stabilization	No	No
A*	Stabilization	No	No
B	Institutionalization	No	Yes
Q	Institutionalization	No	Yes
L	Institutionalization	Yes	No
N	Institutionalization	Yes	No
U	Institutionalization	Yes	Yes
G	Institutionalization	No	No
P	Institutionalization	No	No
H	Institutionalization	No	No
X*	Institutionalization	No	No
Totals	1 Growth 10 Stabilization 9 Institutionalization	7 Yes 13 No	9 Yes 11 No

* Projects marked with an asterisk are rural.

However, despite the apparent lack of major changes in this project, rigid, inflexible institutionalization has not developed. This is reflected in the ethnographers' description of subtle changes in the project: "Although formal goals have been stated from the inception of Project G, actual goals and objectives in practice continue to be clarified and reprioritized." And although there were no major changes in the delivery model for the past year, "refinements have been made to increase internal efficiency, coordination, and supervision of case management." For example, "attempts have been made to increase advocates' and coordinators' direct contact with families."

A similar situation transpired in Project N, which was described by its ethnographer as "moving towards institutionalization." The ethnographer wrote:

> ...the basic goals and philosophy of Project N have remained quite consistent over the course of the project. However, within this basic framework, there have been some important changes and developments in terms of project focus, orientation, and attitude. Some of these changes represent a deepening or further unfolding of certain [project goals], and others represent a shift in emphasis in how project goals are defined or pursued.

Regarding changes in other aspects of the project, the ethnographer wrote:

> There have been several changes in policies, procedures, and means of communication over the history of the project. However, all tend to reinforce the general program approach of teamwork and collective problemsolving. [These changes] result from the emergence of particular problems or gaps in the project's functioning, developments within the families themselves that require adjustments in the program, and requests from the Administration on Children, Youth and Families that certain project issues be given particular attention.

Project G and Project N therefore have been able to begin the transition from the stabilization phase to the institutionalization phase with minimal changes in their organizational structures, goals, and philosophies, while staying flexible to the changing needs of families and staff. Other projects rated as making the transition into the institutionalization phase are doing so under an explicit mandate for expansion of the CCDP model into the wider community. Projects' efforts to expand their bases of operation raise the possibility that new populations will be served and that these new families will have problems, needs, and goals that are different from those of the families currently enrolled. As a result, some projects have decided to take a proactive approach to expansion while simultaneously focusing on ensuring the institutionalization of the project, primarily through the expansion of the projects' funding bases. Also, projects have learned from their successes and mistakes and use this knowledge to adapt their programs to best meet the needs of families and staff. A quotation from Project X's ethnographer illustrates these points:

> One of the hallmarks of the institutionalization phase is the development of new ways to provide services. Project X is implementing a new model for service delivery and is also part of a proposal that could expand service delivery to the community. In late August 1992, the project director and the administrative team guided the implementation of another revision of the service delivery model.
>
> The new model includes a case management component that is more associated with the long-term management of complex cases. This latest configuration reintroduces visits at predetermined intervals by a primary provider. The case manager for each family is responsible for: assessing family needs, developing realistic goals, developing and updating service plans, completing the family service log, advocating for families, and completing MIS documentation and family resource team packets of information.
>
> The new configuration of the service delivery model delineates the case management function among the family support workers, public health nurses, and economic development coordinators. Some families will, of course, need to be reassigned to create equal workloads and to create a caseload for a soon-to-be-hired family support worker. The staff has endeavored to make transitions as least disruptive as possible for the families, which has included having former and newly assigned workers make joint transitional visits.

Finally, the ethnographer noted:

> Another dimension in the institutionalization phase of Project X is the use of local and State funds for the provision of existing services and the identification of sources for eventual continuation of the program. In addition to a possible source of State funding discussed above, Project X, through the project director, has procured local funding since the early growth phase of the project.

This ethnographer's report illustrates the finding that components within projects can develop at different rates (i.e., service components can have lifecycles of their own that are somewhat independent of the lifecycle of the project as a whole).

When asked to comment on major changes that had taken place over time in key components of program services, the ethnographer for Project N wrote:

> The most dramatic change has been in the area of health care from a situation where the project was struggling to just report data on health care usage to the design and beginning implementation of a whole new model of health care delivery. A similar shift has occurred in the role of the project's nutritionist. Thus, the health care services offered by Project N CCDP are now much more comprehensive and also tailored to family choice.
>
> There also have been some changes in the child care component of Project N. First of all, more parents are using or seeking child care than in the first 2 years of the project's life. There has been some success in working with [the local] child care center to develop day care homes that can be used by project families. In [the community], the preexisting preschool now offers its program 4 rather than 2 days a week. This change was initiated by Project N staff to better meet the needs of program families and to address the project mandate for [providing] early childhood education three times a week. Project N families [now] are taking active advantage of the new Head Start programs at the [local] school.

Changes in Goals and Philosophy

As CCDP projects mature, one might assume that the goals and philosophies that define each project also would evolve. An evolution in goals and philosophies may reflect projects' adaptation to changing circumstances or may reflect a conscious effort to change the projects' goals and philosophies. Ethnographers were asked to discuss whether their projects had changed their goals and philosophies and to describe the rationale for changes where this did occur. As shown in Exhibit 4-1, 9 out of 20 ethnographers reported that the goals and/or philosophies had changed at their projects. While these ethnographers did not provide indepth analyses of the reasons for these changes, several conclusions nevertheless can be gleaned from these reports.

First, it appears that projects that have not progressed beyond the stabilization phase are more likely than institutionalized projects to have experienced changes in goals and philosophies (60 percent versus 33 percent, respectively). Although the sample size is too small to produce reliable findings, and the findings are only correlational, this pattern suggests that projects that initiate and adequately maintain the same basic philosophical framework and basic sets of core goals may more readily facilitate the transition from the stabilization phase to the institutionalization phase of development. This issue will be revisited in the final report.

Second, among those projects that did change goals and/or philosophies, it seems there are no differences between stabilized and institutionalized projects in the nature of the changes in goals and philosophies. The major change in goals and philosophies involved the theme of changing from a focus on management of crises to management of goal achievement. For example, an ethnographer from a stabilized project (Project J) wrote: "First, the staff was confronted with stabilizing families, then stabilizing staff, and now the focus is more on relating specific goals to specific steps to be taken by families."

Because of their experiences with families in chronic crisis, some projects realized that they needed to place more effort toward recruiting families that would most benefit from CCDP and reducing the dropout rate. For example, the ethnographer at Project W wrote:

> The degree of transition from crisis management to ongoing assistance was reflected in the fact that Project W made a commitment to focus on recruitment and to conduct a quarterly survey of the replacement group to ensure eligibility for participants who are selected into the program group. Major ongoing goals were established during the early stabilization phase to design an exit procedure which would help reduce the number of participants that leave the program. Several activities have enhanced the team case management approach by improving communication within the resource team to resolve some of the dropout issues. A regular contact process is being carried out by the family consultants to regularly monitor education, training, and employment of program families.

Soon after encountering the many problems faced by low-income families, some project staff came to the realization that they could not solve all problems of all families at once. This new sense of realism was captured in an interview between Project S' ethnographer and project line staff:

> When we first came into the program we were all so excited and were pretty much movers and shakers. We wanted to take everyone from welfare to 100 percent self-sufficiency. That was a somewhat unrealistic expectation, and we had to alter what we really thought we could achieve. We are now looking at each individual parent to analyze their capabilities and guiding them to do the best they can. Some of the parents today can become totally self-sufficient, but some are cognitively delayed, some have a special education diploma, and others simply will not be able to reach the level of achievement that others can.

A critical part of this change in focus from management of crises to management of goal achievement was increased attention in the development of individual needs assessments and individualized service plans (ISP's). The ethnographer from Project B best summed this up when he wrote:

> ...the key to the success of these programs is the development of ISP's by the family coordinators. Once an ISP has been developed, it is incumbent on the program staff to follow a specified plan of action

in order to assure that the individual family goals can be achieved. These goals are reviewed periodically and revised in consultation with the family in order to assure the family of a positive experience. The intended outcome of this structured program is the enablement and empowerment of the family members to continue the goal attainment process begun with the assistance of the CCDP project staff. It is important to note that the ISP's are all in place, and periodic review of goals and statuses now is taking place.

Conclusions Regarding Project Lifecycles

According to the CCDP ethnographers, all but one project reached the stabilization phase by fall 1992. Because each project started out in different contexts, faced different challenges, and had different visions and goals relative to the legislative goals for CCDP, the life history of each project has varied in several ways. Some projects experienced a smooth, linear transition from the startup phase to the stabilization phase, while others repeated the startup phase one or more times before becoming stabilized. In the final report, a complete description of the organizational lifecycles of all projects will be provided.

Although the sample size is too small to yield reliable results, one interesting, tentative correlational finding was that projects that did not change their goals or philosophies appeared to have evolved further than those that experienced changes. The major factor associated with changes in goals and philosophies appears to be the realization on the part of project directors that many of the original families needed a great deal of crisis management. This focus on managing the crises of multiple-problem families hindered projects from focusing on the main goals of CCDP: to foster optimal child development and to facilitate economic and social self-sufficiency. As projects gained more experience working with low-income families, CCDP staff acquired a sense of realism regarding the degree to which families' problems could be addressed adequately and simultaneously. This sense of realism appears to be related to the process of projects making the transition from the startup to the stabilization and institutionalization phases of organizational development.

The information presented in this chapter provides preliminary illustrations of the multifaceted factors affecting the implementation of CCDP projects. The lessons learned thus far about the organizational lifecycles of CCDP projects, together with the lessons to be learned after projects have operated for their full funding cycles, will greatly aid policymakers and program planners who are interested in the feasibility of replicating the most efficient and most effective components of the CCDP model.

REFERENCE

Fottler, M.D., and Smith, H.L. 1988. "The Organizational Lifecycle and Strategic Human Resource Management." In Fottler, M.D., Hernandez, J.R., and Joiner, C.L., eds. *Strategic Management of Human Resources in Health Services Organizations.* New York, NY: John Wiley and Sons, Inc.

Chapter 5. ATTRITION (TERMINATIONS) AND FAMILY SATISFACTION

The conceptual framework for the feasibility analysis and process evaluation presented in Chapter 3 includes attrition, or terminations, as a major process outcome variable. The first part of this chapter presents the preliminary results of analyses of management information system (MIS) data regarding patterns of termination. These analyses are complemented by more indepth qualitative analyses of ethnographers' reports concerning reasons for termination. The second part of this chapter discusses analyses of ethnographers' reports on family satisfaction with the Comprehensive Child Development Program (CCDP). The preliminary results regarding terminations and satisfaction with CCDP suggest areas of projects' strengths and weaknesses. The lessons learned from these analyses can be used by CCDP projects to build on their strengths and rectify their weaknesses.

TERMINATIONS OF CCDP FAMILIES

When parents eligible for enrollment in CCDP are recruited, they are told that a condition of enrollment is their commitment to participate in the project for 5 years. CCDP provides many incentives for families to participate. However, it is inevitable that some families will no longer want or be able to participate (voluntary terminations) or that project directors will terminate some families (involuntary terminations) due to nonparticipation. Within each category of termination, the reasons for termination may reflect factors related to the project characteristics, or they may reflect factors out of the project's control. Also, it is likely that some families may terminate for a single reason, whereas other families may present multiple reasons for termination. Accordingly, it is important to have a variety of data sources to capture the complexities underlying the reasons for terminations.

One significant policy feasibility question that can be addressed by an analysis of terminations is whether family support programs like CCDP can attract and maintain the participation of low-income families that have various needs and goals. Learning more about why families leave CCDP can contribute to understanding how CCDP and other similar programs help families progress toward social and economic self-sufficiency.

This section discusses data on terminations from two complementary sources of data. First, MIS data are examined on the number of terminations among the original and replacement families across the CCDP projects and the number of families that terminated voluntarily or nonvoluntarily (according to the MIS codes) aggregated across projects. The MIS, however, was not designed to capture multiple reasons for terminations and does not permit an analysis of all the complexities associated with terminations. Therefore, a second data source—ethnographers' reports—is used in order to better understand the reasons for attrition.

PROCEDURES FOR OBTAINING DATA

This section discusses procedures regarding the obtaining of MIS data and ethnographers' reports.

Procedures for Obtaining MIS Data

MIS data on terminations covering the period from the projects' inception through March 1993 were utilized to examine the number of families who voluntarily or involuntarily were terminated from CCDP. The data on terminations were drawn from the Family Profile Form, which included codes for 27 possible reasons for termination.[1] The number of terminations by projects and by reasons for termination is presented for both original families (n = 2,318) and replacement families (n = 982).

Reasons for termination fell into two categories: (1) voluntary and (2) involuntary. Exhibit 5-1 following this page lists reasons for termination within each of these categories. Voluntary reasons were divided into four subcategories and involuntary reasons into two subcategories. The four voluntary subcategories are as follows: (1) change in lifestyle (including positive relocation), (2) family no longer needs CCDP services (i.e., it achieved its goals), (3) nonparticipation (including negative relocation), and (4) other/miscellaneous. The two involuntary subcategories are (1) nonparticipation and (2) other/miscellaneous.

Procedures for Obtaining Data From Ethnographers' Reports

In late 1992 ethnographers were asked to investigate the reasons CCDP families either voluntarily ended their participation in CCDP or were terminated from CCDP by the projects. The ethnographers were provided with a list of families that had been terminated as of the July 31, 1992, download of MIS data and then were instructed to obtain an updated list of all terminated families as of October 15, 1992, from the CCDP data manager. Ethnographers then were asked to examine the records of at least 30 randomly selected families that had been terminated officially from

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[1] In the MIS, only one "reason for termination" code could be chosen for each family. Furthermore, one code—inactive status—is used for terminated families that have committed to return to the program after an extended vacation or absence due to temporary employment or schooling located outside the CCDP service area.

Exhibit 5-1

Categories of Reasons for Termination

VOLUNTARY REASONS

Change in Lifestyle

- Relocated to attend jobs, skills, or technical training;
- Relocated to attend educational program/school;
- Relocated to obtain employment;
- Relocated to obtain improved housing;
- Relocated due to marriage; or
- Change in lifestyle.

Family No Longer Needs the CCDP Services

- Achieved goal of obtaining jobs, skills, or technical training;
- Achieved goal of obtaining employment;
- Achieved goal of attending educational program/school; or
- Achieved goal of obtaining improved housing.

Nonparticipation

- Relocation due to loss of job;
- Relocation due to loss of housing;
- Relocation due to incarceration;
- Relocation due to poor health;
- Lack of interest in the program; or
- Unwillingness to participate or comply with project regulations.

Other/Miscellaneous

- Death of focus child or family member; or
- Relocation of focus child for unknown reasons.

INVOLUNTARY REASONS (Terminated by the Project)

Nonparticipation

- Lack of participation;
- Inappropriate behavior;
- Primary caretaker abandoned family;
- Primary caretaker removed from family; or
- Family disappeared.

Exhibit 5-1 *(continued)*

Other/Miscellaneous

- Membership in comparison group;
- Unable to contact family;
- No focus child;
- Income ineligibility;
- Relocation for unknown reasons; or
- Incomplete information.

CCDP and to describe in as much detail as possible the reasons for termination.

RESULTS OF DATA ANALYSIS REGARDING TERMINATIONS

Results regarding MIS data and ethnographers' reports are provided below.

Reasons for Terminations Derived From MIS Data

According to the MIS data, out of 3,300 original and replacement families served by CCDP projects over 2½ years, 1,197 (36 percent) had terminated (Exhibit 5-1 lists the categories of reasons for termination). Exhibit 5-2 following the next page lists the number of terminations by project from the lowest to the highest total percentage of families terminated. Also, the percentage of terminations among the original and replacement families is presented separately by project. These data indicate a wide variation across projects. For example, the percentages of terminations among original families range from 15 percent (Project X) to 68 percent (Project C), and among replacement families they range from 0 percent (Projects E and B) to 45 percent (Project I). Significantly, there was on average a higher percentage of terminations among the original families (40 percent) than among the replacement families (26 percent).

The greater percentages of terminations among the original families may be attributable to the fact that, during the startup phase, projects were under severe pressure to recruit their quota of families by a specific date and thus may have recruited families that were not fully aware of the level and length of commitment that would be required of them. Information obtained from parent focus group discussions held during site monitoring visits suggest that some CCDP projects did not effectively screen families at recruitment to determine those families who were unwilling to fully commit to participating in CCDP services. Many families were interested in receiving only those services that could address their immediate needs, and several ethnographers identified this as a problem. Other families were not clear about the goals and objectives of CCDP.

Exhibit 5-3 presents the number of terminations among the original and replacement families according to reasons for termination. Note first that of the 1,177 total families that terminated (this does not include families on inactive status), 794 (67 percent) voluntarily terminated and 383 (33 percent) involuntarily terminated. Second, among families that were involuntarily terminated, 84 percent of the original families were terminated because they would not participate or because they disappeared (nonparticipation subcategory), compared to 68 percent of the replacement families that were involuntarily terminated for these reasons.

As further seen in Exhibit 5-3, 49 percent of the voluntary terminations were due to families relocating or changing their lifestyles. Some ethnographers interpreted this as a positive behavioral change that is attributable to CCDP enrollment. The reasons for these changes in lifestyle revolved around taking steps toward economic self-sufficiency, such as obtaining a job or attending school.

One way to look at trends in the numbers of original and replacement family terminations over time that control for length of tenure in CCDP is to analyze only those families that had the chance to stay in the program for 1 year and then compare the proportion of original and replacement families that were enrolled in the program for less than 1 year. Exhibit 5-4 following this page includes only families enrolled between the projects' inception and March 31, 1992 (n = 2,876). The bottom row suggests that the proportion of families who were terminated within 1 year of CCDP enrollment was similar regardless of whether enrollment was in 1990 or 1991 (0.19 and 0.20, respectively). However, the proportion of families that lasted less than 1 year appears to be decreasing, as shown by the proportion of terminated families that enrolled in 1992 (0.17). Among families that enrolled in 1990 and 1991, a greater proportion of replacement families terminated within 1 year than did original families. Although more data are needed, the data suggest a decrease in the proportion of families that are being terminated. In the final report, we will be able to confirm or reject this hypothesis and relate the findings to costs.

Finally, it should be noted that, contrary to a "creaming" hypothesis, involuntarily terminated families did not appear to exhibit more problems than voluntarily terminated families. The basis of this tentative conclusion is the fact that involuntarily terminated families reported fewer needs on average (5.4 percent) than voluntarily terminated families reported (6.4 percent). Although reporting bias may explain this difference, it may be that both groups were equally as probable to answer questions about their needs honestly. The final report will examine this in greater detail.

Reasons for Terminations Derived From Ethnographers' Reports

Ethnographers' reports suggested that families sometimes are terminated as a result of CCDP projects' efforts to help them achieve economic and social self-sufficiency. In these cases, terminations can be viewed as reflecting the successes that CCDP projects have had in facilitating family goal attainment. What ethnographers discovered was that voluntary terminations were frequently the result of several interrelated reasons. Whereas some families moved out of the CCDP service area to obtain employment, others moved to obtain employment in a community where child care by relatives was readily available.

Among the families that were terminated by the projects, 80 percent (n = 306; MIS data) were unwilling or unable to participate in CCDP. According to the ethnographers' reports, in some cases nonparticipation

Exhibit 5-2

Numbers of Families Served and Percentages of Families Terminated

PROJECT	TOTAL		ORIGINAL		REPLACEMENT	
	Number of Families Served	Percent Terminated	Number of Families Served	Percent Terminated	Number of Families Served	Percent Terminated
E	73	16%	60	20%	13	0%
B	144	17%	120	20%	24	0%
S	75	21%	60	21%	15	29%
L	150	21%	120	24%	30	7%
X	78	15%	60	15%	18	17%
J	148	30%	120	36%	51	18%
U	158	31%	120	38%	38	8%
K	165	32%	120	38%	45	18%
G	154	32%	120	37%	34	15%
W	179	33%	120	41%	59	17%
Q	159	34%	120	37%	39	26%
N	170	36%	120	43%	50	18%
D	158	36%	120	40%	38	24%
V	148	36%	120	36%	28	40%
P	256	38%	180	47%	76	15%
A	94	40%	60	43%	34	35%
M	206	45%	120	58%	86	28%

Exhibit 5-2 *(continued)*

PROJECT	TOTAL		ORIGINAL		REPLACEMENT	
	Number of Families Served	Percent Terminated	Number of Families Served	Percent Terminated	Number of Families Served	Percent Terminated
H	153	45%	120	46%	33	42%
R	168	48%	98	54%	70	40%
I	200	48%	120	49%	80	45%
C	241	55%	120	68%	121	43%
TOTAL	3,300	36%	2,318	40%	982	26%

Exhibit 5-3

Reasons for Termination

REASONS FOR TERMINATION	ORIGINAL		REPLACEMENT		TOTAL	
	N	Column %	N	Column %	N	Column %
VOLUNTARY REASONS						
Change in Lifestyle (Relocation)	278	44%	60	38%	338	43%
No Longer Needs Program	32	5%	10	6%	42	5%
Nonparticipation	244	38%	80	50%	324	41%
Other	81	13%	9	6%	90	11%
TOTAL	635	100%	159	100%	794	100%
INVOLUNTARY REASONS						
Nonparticipation	239	84%	66	68%	305	80%
Other	47	16%	31	32%	78	20%
TOTAL	286	100%	97	100%	383	100%
TOTAL VOLUNTARY AND INVOLUNTARY REASONS	921	78% (Row)	256	22% (Row)	1177	

Exhibit 5-3 *(continued)*

REASONS FOR TERMINATION	ORIGINAL		REPLACEMENT		TOTAL	
	N	Column %	N	Column %	N	Column %
INACTIVE	14	70% (Row)	6	30% (Row)	20	▨
TOTAL ALL REASONS	935	78% (Row)	262	22% (Row)	1197	100%

Exhibit 5-4

Proportions of Families Enrolled Less Than 1 Year

FAMILIES ENROLLED BETWEEN INCEPTION (1990) AND MARCH 31, 1992	FAMILIES ENROLLED AND TERMINATED BY YEAR							
	1990		1991		1992		TOTAL	
A-No. Enrolled; B-No. Terminated	A	B	A	B	A	B	A	B
ORIGINAL	2,242	426	76	10	---	---	2,318	456
Proportion of Families Enrolled Less Than 1 Year	0.19		0.13				0.20	
REPLACEMENT	63	22	385	81	110	19	558	181
Proportion of Families Enrolled Less Than 1 Year	0.35		0.21		0.17		0.22	
TOTAL	2,305	448	461	91	457	78	2,876*	637
Proportion of Families Enrolled Less Than 1 Year	0.19		0.20		0.17		0.22	

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* Total does not include 347 replacement families that enrolled in CCDP between April 1, 1992, and December 31, 1992, and 77 replacement families that enrolled in CCDP between January 1, 1993, and March 31, 1993. The total including these families is 3,300.

reflected individual or family dysfunction resulting from multiple problems associated with alcohol and other drug abuse or because of lack of support or active resistance by family members. These families typically lived in a chronic state of crisis or exhibited inappropriate behaviors that were discordant with the goals of CCDP. As noted in the ethnographers' reports, some families faced overwhelming problems that even CCDP had trouble addressing.

There are some indications that the number of terminations is declining and that terminations often are due to reasons that reflect the positive effects of CCDP on families' development or reflect factors that are out of the control of the CCDP projects. Termination patterns will be monitored closely over the remaining years of the CCDP projects to determine if the patterns reported in this interim report continue, and a final analysis will be included in the final report.

FAMILIES' SATISFACTION WITH CCDP

Assessment of family satisfaction with CCDP is critical because it offers information about how and why a family utilizes or does not utilize program services. Clearly, if there is a good match between the types of services provided by the program and the kind of assistance needed by families, then families' participation in and satisfaction with CCDP will be facilitated. Furthermore, family satisfaction is an indicator of the quality of CCDP's service components.

This section describes the families' feelings about CCDP's benefits in general, their reactions to specific components of CCDP, and their suggestions for how CCDP could be improved. Information in this section came primarily from Ethnographer's Report No. 5 (covering the time period November 1991 through February 1992).

Solicitation of Parents' Perspectives

Ethnographers were requested to elicit the parents' perspectives of CCDP and its core activities, including case management, child care, parent education, early childhood intervention, employment training, and health and medical services[a]. Ethnographers also asked parents about their feelings regarding parent involvement workshops, relationships with staff, and possible areas for improvement.

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[a] Ethnographers were instructed to select a random sample of parents or to obtain information on family satisfaction from discussions with home visitors or after a group activity (e.g., a parenting class).

Results of Analysis Regarding Families' Perspectives

The results of the analysis of families' perspectives regarding CCDP fell into the following categories: overall satisfaction, satisfaction with core activities, and satisfaction with and participation in parent involvement activities. In addition, results regarding male involvement and staff relationships are provided.

Overall Satisfaction

Two themes arose from the analysis of families' perceptions of CCDP. First, according to the ethnographers, the majority of families interviewed expressed overall satisfaction with CCDP. Families viewed the purpose of CCDP in various ways and, therefore, some families evaluated the programs differently. For example, some families focused their comments on in-home services only and did not mention center-based activities, whereas other families only discussed services for children. Many family members emphasized the CCDP's comprehensive service components and acknowledged that the CCDP project could be useful to their entire family.

According to Project H's ethnographer, parents were more interested in how CCDP could help them in terms of their long-term success as opposed to how CCDP could best help their children in the immediate future:

> Almost every individual interviewed stated that they enrolled in the program in order to get their lives off the ground, to be successful, and to come off welfare. Clients did not state that they had enrolled in the program to help with their children's development, but rather, when mentioning their children, they stated that they were making efforts to progress in their own education and training so as to be able to provide their children with a brighter future. Satisfaction with the program most often was linked with whether or not Project H is perceived to be a facilitator of such long-term goals.

On the other hand, the ethnographer at Project N described how some families emphasized the more comprehensive applications of CCDP:

> Some parents, however, clearly understood the integration of the two aspects (i.e., the child development and the comprehensive service components). They described how the project is promoting their children's immediate development, while also explaining how accomplishing some of their own goals could help them provide a better environment to be a better parent to their children.

Ethnographers noted that, in general, as families' levels of participation in CCDP increased, their evaluations of the program became more positive. Project W's ethnographer observed that parents who indicated a great deal of satisfaction with the project were those who had fully participated in the project. Other parents reported some satisfaction, but they did not participate at as high a level as parents who reported high satisfaction. And finally, the least involved parents reported only minimal satisfaction with the project.

The following comments illustrate how parents who are actively participating in CCDP perceive CCDP services and activities. For example, a parent from Project H told the ethnographer, "I feel like I'm getting everything I need from the program. I'm happy. I've gotten more out of here than I would have on my own."

A woman from Project V was so excited about how the program had helped her that she vowed to go back and help others like herself:

> Project V has done so much for me. I told them that I want to finish my general equivalency diploma (GED), and I want to get training because I want to get involved in Project V too, so I can help people. That's the way I feel. I got to the point where, like, I know a lot of things and stuff, and I could help out people, too. I want to get involved...Now I know where I want to go.

Satisfaction With Core Activities

Families' satisfaction with specific core activities, such as case management, child care, parent education, early childhood intervention, employment training, and health and medical services, are discussed below.

Case Management

Ethnographers asked families to express their feelings about the kinds of services provided by CCDP. Families' perceptions of both their relationships with their case managers and other CCDP staff members and the way in which these relationships affected families' satisfaction with and participation in CCDP are presented in later sections of this report.

Many families acknowledged the comprehensive, integrated, and informative assistance provided by their case managers. At Project N, the ethnographer observed that Ms. K recognized the coordinating role of the case manager—how her case manager "raises things that are linked together." The ethnographer elaborated:

> Ms. K, like many of the mothers I interviewed, saw child care as a difficult problem that needs to be resolved before she can go back to school. Yet she emphasized how her case manager also had raised this point as soon as they began to explore possibilities of further education or training (i.e., the two issues had been worked on together from the beginning). The same was true with Ms. K's goal of moving out of public housing. She appears to have discussed this

> with her case manager but with a full understanding of its relation to her other goals of education and employment.

At Project H, the ethnographer described Ms. Q's feelings about the integrative case management services offered by her CCDP project as follows:

> Ms. Q was involved with Project H because she felt it was "an opportunity to sit down and pay more attention to our children...to see how they are developing." For Ms. Q, the integration of the child development piece and the social service piece of the CCDP is well established; the joint involvement of both she and her husband also seems very important to her...She indicates that their case manager works well with them around all these issues (e.g., parent education and early intervention as well as job training for her and her husband). Ms. Q thought that participation in the program had made her husband more attentive to and involved with all their children and had brought her and her husband closer together.

Ms. W is a 50-year-old grandmother enrolled at Project M. Her 26-year-old deaf and mute daughter is the mother of the focus child (who is 2 years old). Ms. W described the wide range of services included in her case management as follows:

> I am satisfied. They really have helped me with my grandchildren. I have been lucky to get a place like this that could help me. That is why, if I need something, I call Project M and tell my coordinator. If she needs to go to my house, she will go, too. They accompany me when I have to attend school meetings concerning my grandson; they also give me transportation. They would pay for a taxi for me. They interpret for me. They are trying to get my daughter into a special training program. I have no complaints. The program has been very good to me....

Some families are thankful for the information and resources provided through CCDP's case management component. A parent at Project H remarked:

> I like the program. It's the support that I need...That's why I like the project—because it helps me out. You know, it gives me a lot of resources that are out there that I didn't know I could get, you know, and they'll help me with it.

The ethnographer at Project R described another families' favorable perception of information and referral services provided by CCDP as follows:

> During all of the family interviews, all but one of the families stated that CCDP had helped financially by providing them with information or referring them to resources. One family stated that

> they had not received any financial assistance from CCDP, but knew if they needed help, they could ask for it, and CCDP would be responsive.

Finally, the ethnographer at Project P noted a special situation where case management services provided more than information and referral services. In this example, case managers helped a group of Mexican families assimilate to an unfamiliar English-speaking environment:

> A small segment of parents who came from Mexico to Project P were concerned about their inability to function in an English-speaking environment. These Spanish-speaking parents were grateful that the case managers helped them fill out applications for apartments, jobs, and services. One woman said that she had problems understanding the flow of English but was quite good at pronouncing the words that she did know, while her husband understood much when others spoke English but had a terrible time pronouncing and speaking. The sympathy and patience showed by the advocate were much appreciated by these folks, especially since they both intended to advance in their schooling.

Child Care

Many CCDP families appreciated the day care services provided by CCDP projects and especially were impressed by the amount of attention many centers gave to early childhood development. Families' comments about child care are highlighted below.

The ethnographer at Project H commented on the importance of child care to most families at the center:

> When speaking about Project H in general, satisfied participants invariably mention the child care assistance that they receive as a major benefit of the program. Thus [a client] states the following: "I'd say a rewarding experience is having the child care—that's the main priority."

According to the ethnographer at Project K, free child care services are a favorite component of the program because it enables parents to work and attend educational classes. One married mother with two children explained:

> Without it, I'd be back on welfare, or I would have a lower standard of child care. There is one place that would charge me $75 a week per child, but I hope I never have to use it again. You end up with someone who puts the children in front of the TV. They don't have a license and there's a reason why they don't.

One woman at Project X credited the center for turning her life around, and the ethnographer noted how the provision of child care services helped the woman face her problems:

> Before the project, the primary care giver was using drugs and was discouraged about the future. At first, she was happy for the child care so that she could "send the kids off for the day and not be interrupted while I laid on the couch in front of the TV all day." Then, through her conversations with her [case manager]...she realized that she didn't have a life and that she could have one if she wanted.

Parent Education

Overall, families involved in CCDP were pleased with the parenting classes they attended because the classes helped them help themselves and their children. At Project R, for example, many families believed child development classes would help empower them to give their children a better life than they had experienced. The ethnographer explained:

> One mother conveyed that the classes had benefited her and her children. Not only did she feel she was providing educational activities to them, but she also learned how to play with her children. This woman grew up in an alcoholic family and experienced little play time and nurturing as a child. (She only wished someone had provided her with child development education when she had her first two children.)

After attending the classes, many parents remained optimistic about the benefits of parent education activities. Some parents at Project K already had noticed differences in their relationships with their children. Furthermore, parents at Project S believed they had learned a great deal about how children grow and develop through the project's parent education series. The ethnographer at Project S shared the story of a young African-American mother who used parent education classes to dispel myths of childrearing and increase her confidence in dealing with her family:

> The young mother found herself in a town where she knew very few people...[she was] expecting a baby and experiencing difficulties with her pregnancy. She was forced to stop working and returned to live with her widowed aunt who had raised her. Her aunt believed all the old wives tales..."If you turn your baby upside down it will hurt her liver and she'll die...You aren't supposed to play with a child, it's not good for them"....The parent was terribly confused about parenting when Project S entered her life. She quickly says that it has completely turned her life around. She is confident now about how to raise her child, is familiar with the importance of spending time with her child, and is very anxious to get back into the workforce.

According to the ethnographer at Project V, one 24-year-old woman was thankful the program provided her with an opportunity to learn to be a better mother as well as to improve herself:

> Ms. D was born in Mexico and moved to the United States when she was 17 years old. She married her husband when she was 19 years old; he started abusing her physically a short time later. He threatened to take away her children (two boys, 3 years old and 18 months old) if she tried to leave him. Since she entered Project V, Ms. D has attended parenting classes and she told us...that still today her husband makes jokes and wants to make a point in that he knows everything there is to know about being a parent....But no matter what her husband says, things have started to change in her home..."He has changed a lot. He is going to parenthood classes, so he can learn to be a better husband and a better father. I also am learning a lot at Project V, thank God."

Some parents did make suggestions about how the parent education services could be more useful to them. Most families interviewed at Project R believed CCDP has been very helpful in improving parenting skills but wished the center would offer additional parenting education workshops/classes, because many parents felt frustrated and unsure of how to respond to their children. Some parents suggested offering question-and-answer sessions for parents and including information on how to deal with older children.

Early Childhood Intervention

Many parents appreciated the early intervention services provided by CCDP because the services benefited both the children and the parents in a family. For example, at Project U, the ethnographer reported:

> [Some] parents commented that the team members' assessments of their child's special and emotional and physical needs were a source of satisfaction to them. They felt the early intervention was an unanticipated but welcome benefit of enrolling in the program.

A father at Project K commented that "[We benefit most from]...the help they offer with our children to help them grow mentally as well as physically and socially."

Many families also viewed intervention services as affording a chance for them to learn more about their children's development. According to Project R's ethnographer:

> Parents were happy that specialists provided them with information and suggested specific activities to do with the child because it relieved some of the stress of selecting the appropriate activities for their child's development. [One mother] especially likes the

> educational activities and the homemade toys provided by the specialist and believes her child would not be as developmentally advanced without the support her child receives.

Employment Training

Job training services were rated quite satisfactorily by many CCDP families. For example, one ethnographer reported:

> Employment services and/or education are the top priorities for many parents at Project N....This probably reflects parents' own assessments that such training and employment are necessary prerequisites for meeting many other needs.

At Project M, a mother of a 1-year-old son attended the vocational education program with her brother. She commented:

> The vocational training helped me with things I didn't get in school. For example, in school they would teach you how to do an interview, but here I've learned how to do a résumé and cover letter.

At Project U, the ethnographer described the stories of two women who returned to the workforce after obtaining training from CCDP:

> One mother with two children completed a refresher course to be recertified in her field. She was extremely satisfied that [the CCDP project] had been able to pay for her short course and she was now working full time. Another single parent with a daughter had completed a certificate program, and she now was working full time.

Health and Medical Services

Families generally were pleased with the medical services provided. The following examples describe the extent to which some families have valued this service component.

The ethnographer at Project L noted why some families value the project's provision of medical services:

> In general, families are satisfied with medical services. The majority of the [project's] families did not have medical service prior to this program....For the most part, families are satisfied with [one of the clinics]. They feel this clinic always attempts to accommodate them between patients, and they get in even if they have to wait 3 hours.

Project V's ethnographer provided the following story about how one woman's life has been turned around because of the medical services offered by that center:

> Ms. C, 35 years old, is a single mother of three children. She came from Mexico to the United States in search of a better life, but developed a drinking problem during the pregnancy of her first child. After joining CCDP in 1991, she was examined by the CCDP doctor, who took her to a specialist. She had alcoholic hepatitis. Since then, she explained, the social workers and the doctor had been with her all the way. "The doctor from Project V asked me if I wanted to go to one of those groups (Alcoholics Anonymous)"....She said that Project V has helped sometimes with food and with all the visits to the doctor who is taking care of her illness.
>
> Since 1991, Ms. C has kept her promise to herself and has not taken a drink. In addition, she has learned about healthy eating habits and the dangers of drinking while pregnant. Finally, Ms. C is taking an English class in preparation for the GED exam. She says, "Now...I can think about another type of life for me and my children. I don't want to die and leave my children alone."

Participation in and Satisfaction With Parent Involvement Activities

As discussed previously, CCDP families typically were more satisfied with parent involvement activities (e.g., the parent council, the project advisory board, craft classes, newsletters, and fundraisers) if they were active participants in the programs. In addition, Project J's ethnographer observed that most of the active family members have established strong friendships and support networks. It appears that relationships with other parents tend to encourage participation.

Like many families in other projects, Project C parents' main reason for participating in CCDP-sponsored activities was to socialize and seek support from other parents in similar situations. At Project K, one father described his new-found sense of belonging as follows:

> [I feel] real happy. It gives us a chance to get out and see other parents in the community—parents who are like us. We don't feel like we're the only ones going through these things. We hear other people's problems and meet neighbors.

In addition, the ethnographer at Project U discussed how participation in parent activities helped a woman develop a stronger sense of herself:

> [She] has strains in her relationship with her spouse and is working through challenging situations with her children and her spouse. She has stated that her involvement in the group activities of [the project] and her active role in leading meetings and working with other parents has built her sense of self-esteem. "All I have is negative at home. But I come here and people listen to me. I can get things done. I can be somebody, and I get all the positives."

At Project N, parents not only value the opportunity to socialize and to improve their self-esteem but believe that, as a result of their participation in CCDP, they have learned important skills, such as how to make joint decisions and how to build and maintain effective groups. Project N's ethnographer summarized a parent's comments as follows:

> ...another goal of the parent council [is] decisionmaking. This has several dimensions. First, there is simply the experience of working together in a group...Thus, one [parent said], "[The parent council] is a chance to use your mind, a chance to learn how to communicate." There is also the aspect of making your own decisions as a group, planning what you want to do, and carrying out your plans. One parent asserted, "I come back because I'm interested in it—making decisions—where we go, how we go"....At the moment, the main things that parents are deciding about and doing as a group are the social activities and fundraising events.

One parent explained that her learning experiences included finding out information about community resources and that this was her main reason for participating in involvement activities. She said, "That's what I like about these [parent group] meetings—the more you go, the more you find out."

Male Involvement

All CCDP projects have at least one staff member whose responsibility it is to address the needs, problems, and goals of CCDP male family members in conjunction with other CCDP staff members. Most projects also make available special programs and activities for males (see Chapter 2). These programs typically are designed as a way to "hook" males into the project with recreational or male-oriented activities. For example, some families at Project M have suggested that the program offer more activities for males.

It appears that some males are becoming increasingly involved in CCDP activities, although there is wide variation in the level of male involvement and participation across and within CCDP projects. Also, there appears to be two levels of male participation—(1) "male-oriented" activities, usually including athletic and other recreational projects, and (2) more consistent and more serious commitments. Following is a description of Project S' attempt to include men in its program:

> There are some efforts being made to do more male-oriented things, and when these activities are offered, the males do come. A recent business council-sponsored event was the opportunity to attend a university basketball game. Fifteen project families attended along with business council members. Those attending thought it was great!

At some CCDP sites, men are participating in more substantive activities. Some men pursue activities that may help them find employment, whereas others are interested in learning about their children's development. Project K's ethnographer noted that fathers participate most in the areas of education, job training, and employment services; special events; and medical and dental services.

At Project N, some fathers have become very interested in learning about child development. The ethnographer commented:

> One thing [some] of these men have in common is a keen interest in their children's development and their positive evaluation of the child development component of the project. [Most] of them participate regularly in the weekly sessions with their children. Each one also reported that this was the main reason they were drawn into CCDP in the first place. "When the family advocate and community organizer first stopped by, they explained the program...it seemed interesting, especially something dealing with children....Their work with the children is what got my interest in the program," said one father. This father signed his family up right then, not realizing his wife already had filled out an application.

At Project U, a father who was very interested in how the program could help him plan for his family and for its future made the following comment:

> I want to have an ongoing relationship with someone who will help us with long-term goals...I'm not sure how to organize this. I'm having a hard time to just establish our family life.

The ethnographer explained that this father was receiving adequate assistance in reaching short-term goals and was now ready to look at long-range goals.

At Project K, one Latino father had hesitated about attending project events but eventually felt comfortable participating with a few other men:

> At first, I was kind of uneasy because I was the only male...I used to see all the ladies and wonder, "Could I say these things without hurting their feelings or getting myself in trouble?" But now it's like one big family.

Staff Relationships

Ethnographers also were asked to evaluate the nature and quality of the relationships between the families and staff members. Several ethnographers noted that (1) there was a strong correlation between a family's relationship with its case manager and its degree of satisfaction with CCDP services and (2) most families were more than satisfied with the quality of their relationships with project staff.

At Project I, some families reported that their most rewarding experience with the program was their relationship with their case managers. One woman, who joined the program as a result of a door-to-door recruitment campaign, had two children who were involved in the center's child care program. She told the ethnographer that "I am fortunate. I have an excellent relationship with my home visitor. We are friends...I am motivated by friendship and personal commitment."

At Project M, one woman also described how much she relied on her case manager:

> She comes by every Monday, and we do things with the kids. Even at night, I can call her. If I can't get her, I don't talk with anyone else. I wouldn't change my advisor for the world.

Families in other projects also praised their family advocates: "My family advocate goes beyond the hours she's paid for," says one parent in Project D, "Of all the family advocates in the project, my family advocate is the best."

When asked what was the most important part of the program to her, a Spanish-speaking woman from Project P told the ethnographer: "Quiero mucho a [advocate's name]...Ya la siento como mi familia." ("I love my advocate very much. I already feel like she is family.")

Families' Suggestions for Improving CCDP

In this subsection, we summarize the ethnographers' findings regarding families' suggestions about how CCDP could serve them more effectively and/or more efficiently. Families presented their ideas on a wide range of topics, from child care to staff turnover to poor communication among staff and between staff and families. Ethnographers noted, however, that many families offered these suggestions after expressing high satisfaction with the overall CCDP services. In addition, all project directors have reviewed the specific suggestions and have been encouraged to take supportive actions.

Child Care

Although ethnographers noted that many families found the child care services helpful, many families believed the centers' hours were much too limited for them to look for a job or to accommodate their existing work schedules. An ethnographer at Project U reported:

> The discussion group parents felt that if this program was to prepare them for working in the "real world," it should be providing realistic day care. That is, child care should be open from 6 a.m. to 6 p.m., with lots of space available so children could be dropped off at any time....Specific comments included the following: "How do they expect us to work if they don't give us child care? You can only work

> between 10 o'clock and 3 o'clock! Who manages that?" and "They have to make more hours available. You can't make an appointment and look for a job only 2 hours a day. If I get ready to look for a job I want to do it all day."

One staff member of Project I made a suggestion about improving day care service hours, which would require a commitment by the families as well as the day care center:

> I would like to see a 7-day, extended-hours center. I would like to see families helping families by bartering services. I would like to see extended child care, with families donating a specific amount of time to see that happen.

Staff Relationships

Although ethnographers reported that most families maintained close relationships with staff, some families expressed dissatisfaction with issues of staff availability and turnover, differences in culture and language, and poor communication. Each of these issues is discussed below.

Staff Availability and Turnover

Families would like to see less training and other demands placed on their advocates so that the advocates can be more accessible to the families. The ethnographer at Project P reported the frustration that some families were experiencing in trying to access project staff:

> One parent was told that the reason it had been impossible to reach her advocate was the amount of training that was being commanded of her and the fact she was in the field a lot. Others said they felt their advocate was overworked...with too many workshops and training. As she said, "I think its just the program, 'cause every time they say she's in assignment and training, they have her gone all week." Whether or not her perception was entirely on mark, this parent felt that the program should go easier on the training and other demands placed on her advocate.

Several families expressed dissatisfaction or confusion when CCDP staff were replaced or relocated, or when they left CCDP, often without telling the families in advance.

At Project U, the ethnographer noted:

> These comments reflect parents' fatigue and desire for some stability in their lives. One client asked, "Who's on my team now? They keep changing." Another commented, "I get tired of there always being a new person."

Cultural and Language Issues

Families believed that the problems they had experienced with staff could be attributed to differences in culture and language. For example, the ethnographer at Project L learned that some families felt staff were taking too strong a hand in mandating how the families should live their lives. Some suggested that the staff's dissimilar background and culture may have influenced the staff's unwelcome behavior.

At Project I, the ethnographer observed conflict/issues of diversity embedded in some parents' concern about their children's health:

> Parents and staff sometimes misread each other. For example, staff may observe a health issue and contact the parent for information and assistance. The parent in turn may interpret the inquiry as an indictment against [his/her] care of the child in question. Part of the suspicion is based on cultural differences....

Communication issues

Poor communication among and between staff and families has generated concern and frustration in several CCDP programs. At Project K, parents feel that communication needs to be stronger among project staff members and between the project and families. One parent told the ethnographer:

> Staff members should communicate better with each other. It's like everybody constantly is having meetings, but a lot of times the right hand doesn't know what the left hand is doing. I was concerned about that in the summer because some of the staff thought I had quit the program, and I specifically had told them that I wasn't quitting. I thought everybody knew that, you know, but they didn't....Why didn't everybody listen?

In addition to witnessing communication difficulties among staff, ethnographers reported that many families received from the staff either incorrect, outdated, or incomplete information about core services, programmatic changes, and scheduling issues. For example, at Project K, many parents commented that they were not made aware of available services, such as counseling and support groups, housing assistance, and dental care. Parents also mentioned lack of advance notice about upcoming events (e.g., advisory board meetings, special events, and parent education classes) as a reason why they were dissatisfied with elements of CCDP.

Scheduling Issues

Ethnographers observed that a question frequently asked by CCDP families that participated in CCDP workshops, day care programs, and parent education sessions is, "Whose schedule are these days/times supposed to accommodate?" There appears to be a conflict between which timeslots are more beneficial for staff versus those which are more convenient for parents. It is often very difficult for parents to attend workshops and sessions during the day because they either work or attend classes.

The ethnographer at Project P noted that there appeared to be a problem in coordinating schedules with parents and getting enough parents to participate in the activities. Furthermore, at Project B, the ethnographer explained how scheduling issues prevented families from receiving a full range of services:

> On the day I interviewed the site coordinator, a play group had been scheduled, but the person responsible for doing it did not show up. Fortunately, neither did any parents or children. The parent trainings are no more consistent than the play groups....The sites have had little or no ongoing communication regarding what activities will be offered and when. Since project staff are unaware of the days and times of these activities, information is not disseminated to family members. The family advocates said that they were concerned about telling their families about the play groups and parent trainings since they often were not held as scheduled.

Transportation

Ethnographers noted that some families are motivated to participate in CCDP program activities because the CCDP offers them transportation to service locations. Limited hours was the most often mentioned issue of concern for families who utilized the programs' transportation services, although some worried about the advanced planning necessary to receive services and about the difference between the amount of transportation promised to them and the actual amount they received.

The ethnographer at Project U explained how inaccessibility to transportation affected families' use of other services, such as child care:

> Parents who were interviewed stated that one source of frustration was that the van run comes too late in the morning to pick up the children. These parents made their own arrangements to transport children. [Others] stated that the van would drop off children too early in the afternoon, when parents work until 4 or 5 o'clock.

Conclusions Regarding Families' Satisfaction With CCDP

A family's level of familiarity and comfort with various CCDP components affects the family's participation in and satisfaction with the overall CCDP program. Many families rely on their case managers and other parents to help them become more involved in the CCDP projects, and most families depend on those personal relationships to remain optimistic about their own family's long-term outcomes. CCDP projects appear to be quite successful in addressing many families' needs in terms of core services and parent involvement activities. However, comprehensive child care services (with extended hours during the evenings and weekends), modified parenting and job training programs, more consistent relationships with staff, and clear interstaff and staff-family communication were suggested by CCDP families as areas needing improvement. Many CCDP project staff already have implemented these changes. The fact that family members are able to articulate their thoughts about how CCDP could be improved and offer positive solutions is an indication that many CCDP families have taken "ownership" in their CCDP projects.

Chapter 6. FAMILY- AND INDIVIDUAL-LEVEL NEEDS, SERVICE RECEIPT AND UTILIZATION, AND GOAL ATTAINMENT

Case managers are actively involved in the ongoing process of assisting families in assessing their needs and goals, developing and reviewing service plans based on these assessments, educating families, brokering and referring families to needed services, and monitoring family progress toward achieving goals.[1]

A needs assessment is conducted with individual family members and the family as a whole at least once every 6 months. While some Comprehensive Child Development Program (CCDP) projects developed their own assessment processes and instruments, all projects must record this information on a common management information system (MIS) form. The MIS assessment form contains a listing of more than 40 potential needs, such as vocational training, housing, education, and child care. Case managers actively involve families in this needs assessment process. Joint participation in goal development facilitates the process of helping families plan priorities in their lives and ultimately take responsibility for their own welfare. Furthermore, the strategy of enlisting families' support in the development of service plans is designed to foster a sense of empowerment and control over their own destinies and to decrease modes of thinking and behaviors that maintain dependency.

This chapter is divided into three sections. In the first section, a quantitative analysis is presented of (1) the percentages of families and individual family members who identified specific needs and goals, (2) how well CCDP staff respond to these needs and goals, and (3) families' and family members' progress toward goal attainment from project inception through March 1993. The second section presents a quantitative analysis of family service utilization patterns in the first half of Fiscal Year (FY) 1993 (October 1, 1992, through March 31, 1993). Finally, the third section provides a qualitative perspective on needs reduction and goal attainment in the form of CCDP participants' "success stories." Together, information examined across all three sections provides a picture of CCDP families' progress toward empowerment and self-sufficiency.

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[1] Case managers work with family members to complete needs assessments and goal development for the family as a whole and for individual adults and children. Likewise, service plans are written to address the needs and goals of families and individual adults and children.

DESCRIPTION OF NEEDS AND GOALS

For illustration purposes, needs and goals have been classified in this report either as (1) areas which address deficit reduction or (2) areas which address empowerment. Deficit reduction includes attending to survival issues and basic necessities, such as transportation, health services, and food. These necessities are, for the most part, related to basic survival. On the other hand, the reduction of needs related to empowerment tends to facilitate independence and growth. Issues that relate to empowerment include employment and income, education and training, self-efficacy, and the size of one's social support network.

Needs and goals related to deficit reduction and empowerment are described by the MIS data base, as summarized in Exhibit 6-1 following this page. As these examples illustrate, deficit reduction has to do with life's basic necessities and with overcoming dysfunctional behaviors and relationships. We categorize these needs and problems as deficit reduction because they focus on completing the first necessary steps to overcoming barriers needed to focus on achieving social and economic self-sufficiency. For example, family members need to be physically and mentally healthy and have reliable transportation before they can plan longer range goals related to securing jobs and furthering their education. Furthermore, families experiencing chronic inner turmoil due to physical or alcohol and other drug abuse may have difficulty focusing on other basic problems and needs and may find it impossible initially to set long-term goals relating to self-sufficiency.

Empowerment issues go beyond obtaining the basic necessities or ameliorating immediate family and/or individual dysfunction. They relate to enhancing family economic and social growth and individual family member problemsolving, self-control, self-esteem, and coping skills. Empowering family members means that individuals are able (1) to identify and define intrinsically for themselves or for their dependents long-term goals which are important to them and (2) to identify the means for achieving these goals. Furthermore, empowerment implies that individuals believe that the goals they set actually are attainable. The greater this belief, the greater will be the level of effort individuals expend to achieve these goals. One example of an empowerment goal is to become part of a social support network. Another is to access, independently, needed community resources. CCDP is a program designed to simultaneously address deficit reduction needs in the short term and empowerment needs in the long term.

CCDP RESPONSIVENESS TO NEEDS AND GOALS

Preliminary results addressing how CCDP has responded to addressing family and individual member needs are discussed below, followed by

Exhibit 6-1

MIS Codes for Needs and Goals Categorized As Reflecting Either Deficit Reduction or Empowerment[1]

DEFICIT REDUCTION NEEDS	EMPOWERMENT NEEDS
Child Care Housing, Clothing, Transportation, Nutrition, Health Care, Social Isolation, Child Abuse & Neglect, Spouse Abuse, Marital/Partner Relationship, Sibling Relationship, Parent/Child Relationship, Physical Health, High Blood Pressure, Overweight, Blindness or Visual Impairment, Deafness or Hearing Impairment, Speech Impairment, Dental Health, Physically Impaired, Drug Abuse, Alcohol Abuse, Smoking, Mental Illness, High Stress, Learning Disability, Literacy, Basic Life Skills, Chronic Health Problems Related to Birth, Developmental Disability	Income, Parenting Skills, Home Management, Community Resource Usage, Family Planning, Self-Aspiration Level, Aspiration Level for Child, Self-Esteem, English as a Second Language, Education Level, Vocational Skills, Employment
DEFICIT REDUCTION GOALS	**EMPOWERMENT GOALS**
Child Care, Housing, Clothing, Transportation, Nutrition, Health Care, Marital/Partner Relationship, Sibling Relationship, Parent/Child Relationship, Acute and Chronic Health Care, Physical Therapy, Drug/Substance Free, Stress Reduction, Family Relationship, Mental Health, Literacy, Basic Life Skills, Special Education	Income, Extended Support Network, Parenting Skills, Home Management, Community Resource Usage, Furthering Education, Technical/Vocational Training, Language Skills, Economic Self-Sufficiency, Employment, Self-Efficacy, Social Support Network, GED/HS Diploma, AA, CDA, BA/BS, Advanced Degree, Vocational Certificate, Cognitive Development, Social Development, Physical Development, Educational Skills

[1] The needs and goals that are shaded are available in the data base at the family level. The entire set of needs and goals shown above (including those shaded) are available for "individual family members."

findings on how much progress families have made thus far in attaining their goals.

Family-Level Needs

Exhibit 6-2 following the next page displays the percentage of families that identified specific needs, the percentage of families that received at least one type of service in connection with each need, and the average number of different unique types of services these families received or utilized in connection with each need.[2] The number of actual times families received these services is not included in this exhibit. These data are included in a later section of this chapter, CCDP Core Services Utilization.

As seen in Column 2 of Exhibit 6-2, a large percentage of CCDP families identify similar needs:

- Deficit reduction-type needs, such as improved housing (66 percent), child care (62 percent), transportation (58 percent), and health care (58 percent); and
- Empowerment-type needs, such as the need for improved parenting skills (67 percent), increased income (52 percent), and community resource usage (48 percent).

Examples of problems and needs less commonly identified for families include child abuse/neglect (6 percent), spousal abuse (6 percent), and better sibling relationships (11 percent).

Once a need is identified and a goal articulated, the case manager assists the family and each family member in identifying a series of activities and services that will help move the family or family member toward achieving the goals. Services received by family members and families as a whole are recorded in the MIS. For example, a family member who chooses smoking cessation as a need that he/she wants to meet may attend smoking cessation counseling; this attendance would be recorded in the MIS. It is also possible to address a problem or need with several types of time-phased services. For example, if housing is a problem for a family, multiple services can potentially address this need at different times in a family's growth cycle, including temporary housing/shelter, low-rent public housing, rent subsidy (private housing), low-income mortgage assistance, home improvement assistance, and utilities assistance.

Services received by a family may be provided directly by CCDP staff, by a contractor in the private sector, or by another public or community agency.

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[2] See Appendix 6A following this chapter for a listing of the many different types of services families received under CCDP. Appendix 6B provides a list of needs as well as the corresponding service codes used in Exhibits 6-2 through 6-4.

In many cases, projects help families by brokering services through outside agencies. The MIS data presented in Column 3 of Exhibit 6-2 indicate that CCDP projects have been successful in their attempts to provide multiple services in connection with the needs identified by families. In only one category of deficit reduction needs (e.g., clothing) and one category of empowerment needs (e.g., home management) did less than 100 percent of families receive or utilize on average at least one type of service in connection with their needs.

The data presented in Column 4 of Exhibit 6-2 reflect the average number of different types of services received or utilized by families in connection with each stated need.[3] These data indicate that for one-half of the deficit reduction needs (six), at least two different types of services were used by families for each such need. For another five needs, between one and two different types of services were received. This suggests that CCDP case managers have been resourceful and responsive in targeting different types of services to the problems faced by CCDP families. For example, the reported problem of "social isolation" has been addressed in a variety of ways, including through participation in parent/peer support groups, recreational activities, and the provision of transportation.

Individual-Level Family Member Needs

Exhibit 6-3 following this page displays the percentage of family members that identified specific deficit reduction needs, the percentage of family members that received at least one type of service for each need, and the average number of different types of services these family members received or utilized in response to each need. Exhibit 6-4 presents similar information as it relates to the empowerment needs of individual family members.

In the area of deficit reduction, the only needs identified by at least one-third of family members were health related (i.e., physical health, 36 percent; nutrition, 34 percent; and dental health, 33 percent). Not surprisingly, parents view such needs as transportation (14 percent), child care (5 percent), and housing (3 percent) as family problems and not individual problems (i.e., the corresponding percentages in Exhibit 6-2 for families are 58 percent, 62 percent, and 66 percent, respectively).

Based on the data in Column 2 of Exhibit 6-3, the most pressing problems facing most CCDP family members were related to nutrition (34 percent), physical health (36 percent), dental health (33 percent), high stress (15 percent), social isolation (15 percent), and health care (10 percent). Projects

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[3] This analysis was accomplished by first checking the Family Needs Assessment Form to identify who reported a need. Then, the Contact Summary Form was checked to determine how many of these families or family members have received at least one type of service corresponding to the identified need. The number of different types of services a family received in connection with a stated need then was determined.

Exhibit 6-2

Percentages of Family Needs Identified and Types of Services Received[1]

(1) Type of Need	(2) Percent of Families Identifying Need	(3) Percent of Families Receiving at Least One Type of Service	(4) Average Number of Different Types of Services Received
DEFICIT REDUCTION			
Housing	66%	100%	1.08
Clothing	29%	60%	0.60
Transportation	58%	100%	1.17
Nutrition	42%	100%	1.77
Health Care	58%	100%	2.81
Social Isolation	24%	100%	2.61
Child Abuse/Neglect	6%	100%	2.98
Spouse Abuse	6%	100%	1.83
Child Care	62%	100%	4.52
Marital/Partner Relationship	27%	100%	1.37
Siblings Relationships	11%	100%	2.37
Parent-Child Relationships	37%	100%	3.84
EMPOWERMENT			
Parenting Skills	67%	100%	4.17
Home Management	38%	47%	0.47
Community Resource Usage	48%	100%	4.70
Income	52%	100%	2.30

[1] Percentages are based on a sample of 2,749 families using data from program inception to March 31, 1993. Note that some families may have multiple needs.

Exhibit 6-3

Percentages of Individual Family Members' Deficit Reduction Needs Identified and Types of Services Received[1]

(1) Type of Need	(2) Percent of Family Members Identifying Need	(3) Percent of Family Members Receiving at Least One Type of Service	(4) Average Number of Different Types of Services Received
Child Care	5%	100%	2.06
Housing	3%	51%	0.51
Clothing	3%	39%	0.39
Transportation	4%	100%	1.02
Nutrition	34%	56%	0.56
Health Care	10%	64%	0.64
Social Isolation	15%	100%	1.33
Child Abuse and Neglect	2%	100%	1.74
Spouse Abuse	3%	98%	0.98
Marital/Partner Relationship	2%	55%	0.55
Sibling Relationships	1%	28%	0.28
Parent/Child Relationship	5%	100%	1.25
Physical Health	36%	98%	0.98
High Blood Pressure	3%	3%	0.03
Overweight	8%	66%	0.66
Blindness or Visual Impairment	5%	68%	0.68
Deafness or Hearing Impairment	3%	6%	0.06
Speech Impairment	5%	9%	0.09
Dental Health	33%	15%	0.15
Physically Impaired	2%	4%	0.04
Drug Abuse	3%	78%	0.78

[1] Percentages are based on a sample of 11,010 individual family members using data from program inception to March 31, 1993. Note that the same family members may have multiple needs.

Exhibit 6-3 *(continued)*

(1) Type of Need	(2) Percent of Family Members Identifying Need	(3) Percent of Family Members Receiving at Least One Type of Service	(4) Average Number of Different Types of Services Received
Alcohol Abuse	4%	58%	0.58
Smoking	7%	1%	0.01
Mental Illness	4%	76%	0.76
High Stress	15%	100%	1.89
Learning Disability	4%	100%	1.86
Literacy	4%	19%	0.19
Basic Life Skills	9%	31%	0.31
Chronic Health Problems Related to Birth	4%	2%	0.02
Developmental Disability	6%	60%	0.60

Exhibit 6-4

Percentages of Individual Family Members' Empowerment Needs Identified and Types of Services Received[1]

(1) Type of Need	(2) Percent of Family Members Identifying Need	(3) Percent of Family Members Receiving at Least One Type of Service	(4) Average Number of Different Types of Services Received
Income	3%	92%	0.92
Parenting Skills	6%	100%	2.61
Home Management	2%	47%	0.47
Community Resource Usage	20%	100%	2.71
Family Planning	11%	12%	0.12
Self-Aspiration Level	17%	100%	1.62
Self-Esteem	24%	52%	0.52
English as a Second Language	6%	33%	0.33
Education Level	27%	89%	0.89
Vocational Skills	17%	51%	0.51
Employment	26%	100%	2.00

[1] Percentages are based on a sample of 11,010 family members using data from program inception to March 31, 1993. Note that the same family members may have multiple needs.

were able to address one-half of these needs (physical health, high stress, and social isolation) with at least one type of service, whereas less than one type of service on average was brought to bear on the other three needs (nutrition, health care, and dental health).

While 52 percent of the families identified increased income as a need (Exhibit 6-2), only 3 percent of individual family members identified this as a need (Exhibit 6-4). A similar pattern was revealed for other needs related to empowerment (e.g., parenting skills, home management, and community resource usage). Approximately one-fourth of CCDP individual family members identified education level, employment, and self-esteem as important needs to be addressed. Vocational skills and self-aspiration level were identified by even fewer individual family members (17 percent of family members for each), and still fewer mentioned family planning (11 percent). Only 6 percent of individual family members mentioned the need for instruction in English as a second language. With only 27 percent of all CCDP families reporting a Hispanic origin, this represents a proportionally small number of family members identifying this need.

Based on data in the second column of Exhibit 6-4, it is evident the greatest needs related to empowerment were education level (27 percent), employment (26 percent), self-esteem (24 percent), community resource usage (20 percent), vocational skills (17 percent), and self-aspiration (17 percent).

Column 3 of Exhibit 6-4 indicates that for 4 of the 11 needs relating to empowerment (parenting skills, community resource usage, self-aspiration level, and employment) all individual family members identifying these needs received more than one type of service related to that need. An average of 2.23 different types of services was received for these four needs. The percentage of individual family members receiving services in response to the four remaining needs was as follows: increased income (92 percent), a higher educational level (89 percent), improved self-esteem (52 percent), and vocational skills (51 percent).

Family-Level Goals and Progress

Exhibit 6-5 following the next page displays data on the percentage of families that identified specific goals related to deficit reduction, including housing (69 percent), child care (65 percent), transportation (58 percent), and health care (57 percent), as major goals. To enhance empowerment, 67 percent of the families identified parenting skills as a goal for their family, 47 percent identified community resource usage, and 48 percent identified increased income. These percentages are comparable to those reported earlier for family needs. Not surprisingly, families connect need(s) reduction and goal(s) attainment for both specific immediate survival areas and for specific longer term improvement in the overall quality of a family's life.

Exhibit 6-6 following this page presents data on the percentage of families that have either achieved or made progress toward achieving their goals. Of the major deficit reduction goals identified (i.e., housing, child care, transportation, and health care), more than 80 percent of the families have either achieved or made progress toward achieving these goals.

Exhibit 6-6 also indicates that most families have made progress toward achieving goals that enhance empowerment at this fairly early stage of their CCDP enrollment. For example, 93 and 94 percent, respectively, of families made progress toward or achieved their goal of using community resources and improving their parenting skills. Eighty-six percent of the families have made progress toward attaining improved income, while only 14 percent indicated that no progress has been made to date. As reflected below, many families are involved in vocational training or improving their education—important steps toward realizing the goal of earning sufficient income.

Individual-Level Family Member Goals and Progress

Exhibit 6-7 presents data on the percentage of individual family members who identified specific goals and the percentage of individuals who have made progress toward achieving each goal. Goals are grouped according to the following major categories: education, health, mental health, relationship skills, skills, and other.

Education has been a major goal for many family members who view this as a stepping stone toward independence. As is evident in Exhibit 6-7, 77 percent of individual family members made progress toward, or actually achieved, their goal of earning a GED (general equivalency diploma) or high school diploma. Even more impressive is the finding that 80 percent of individuals expressing improved education as a goal made progress toward or achieved this goal, 91 percent of those who aspired to achieve a bachelor's degree made progress toward or achieved this goal, and 77 percent of those who wanted an advanced degree made progress toward or achieved this goal. In addition, under the skills goals, 63 percent of family members made progress in obtaining a vocational certificate, while 23 percent already had achieved this goal. More than 90 percent of family members striving for improved education had improved or achieved their educational skills, and approximately 90 percent of family members (mostly children) also have progressed in enhancing their cognitive, social, and physical development.

In interpreting these data, it is important that the context of the families' tenure in the program be considered. As shown earlier, the average family has been enrolled in CCDP for only 25 months. Attainment of many of these goals requires a substantially longer enrollment. For example, obtaining a job to enable a family to become economically self-sufficient usually requires attaining a number of intermediate goals over a relatively long period of time. This is particularly true for typical CCDP family members who may not have a high school diploma, may not speak English,

Exhibit 6-5

Percentages of Goals Identified by CCDP Families[1]

Type of Goal	Percent of Families Who Identified Each Goal
DEFICIT REDUCTION	
Housing	69%
Clothing	28%
Transportation	58%
Nutrition	41%
Health Care	57%
Child Care	65%
Marital/Partner Relationship	28%
Sibling Relationship	10%
Parent-Child Relationship	36%
EMPOWERMENT	
Extended Support Network	24%
Parenting Skills	67%
Home Management	36%
Community Resource Usage	47%
Income	48%

[1] Percentages are based on a sample of 2,694 families using data from project inception to March 31, 1993. Note that the same families may have multiple goals.

Exhibit 6-6

CCDP Family Goal Attainment and Progress[1]

(1) Family Goals Identified	(2) Percent of Families Who Made No Progress Toward Achieving Goal	(3) Percent of Families Who Made Progress Toward Achieving Goal[2]	(4) Percent of Families Who Achieved Goal[3]
DEFICIT REDUCTION			
Housing (n=1,394)	16%	53%	31%
Clothing (n=530)	29%	69%	19%
Transportation (n=1,216)	10%	65%	25%
Nutrition (n=885)	5%	79%	16%
Health Care (n=1,216)	4%	79%	18%
Child Care (n=1,329)	11%	55%	34%
Marital/Partner Relationship (n=552)	20%	74%	6%
Siblings Relationships (n=193)	9%	77%	14%
Parent-Child Relationships (n=712)	5%	87%	8%
EMPOWERMENT			
Extended Support Network (n=465)	9%	78%	13%
Parenting Skills (n=1,458)	6%	87%	7%
Home Management (n=724)	11%	80%	9%
Community Resource Usage (n=935)	7%	81%	12%
Income (n=932)	14%	76%	10%

[1] Percentages are based on a sample of 2,694 families.

[2] This category includes those who are stated to have made "initial progress," "some progress," or "much progress."

[3] This category includes those families whose "goal is no longer applicable," implying that the goal was achieved.

Exhibit 6-7

CCDP Family Member Goal Attainment and Progress[1]

(1) Family Member Goals Identified	(2) Percent of Family Members Who Made No Progress Toward Achieving Goal	(3) Percent of Family Members Who Made Progress Toward Achieving Goal[2]	(4) Percent of Family Members Who Achieved Goal[3]	(5) Deficit Reduction (D) or Empowerment (E)
EDUCATION				
Furthering Education (n=2,069)	20%	72%	8%	E
Technical/Vocational Training (n=1,019)	30%	62%	8%	E
Literacy (n=200)	38%	53%	9%	D
Special Education (n=94)	12%	79%	9%	D
GED/HS Diploma (n=1,186)	23%	51%	26%	E
Alcoholics Anonymous (n=216)	15%	81%	4%	E
BA/BS (n=173)	9%	76%	15%	E
Advanced Degree (n=43)	23%	65%	12%	E
HEALTH				
Nutrition (n=3,014)	5%	83%	12%	D
Health Care (n=834)	6%	87%	7%	D
Acute Health Care (n=1,828)	7%	78%	15%	D
Chronic Health Care (n=927)	7%	81%	12%	D
Physical Therapy (n=156)	8%	71%	21%	D
MENTAL HEALTH				
Drug/Substance Free (n=434)	29%	55%	16%	D
Stress Reduction (n=909)	17%	79%	4%	D
Self-Efficacy (n=656)	18%	78%	4%	E
Mental Health (n=465)	20%	75%	5%	D

[1] Total sample size = 10,543 using data from program to March 31, 1993. Note that the same family members may have multiple goals.

[2] This category includes those who are stated to have made "initial progress," "some progress," or "much progress."

[3] This category includes those whose "goal is no longer applicable," implying that the goal was achieved.

Exhibit 6-7 *(continued)*

(1) Family Member Goals Identified	(2) Percent of Family Members Who Made No Progress Toward Achieving Goal	(3) Percent of Family Members Who Made Progress Toward Achieving Goal	(4) Percent of Family Members Who Achieved Goal	(5) Deficit Reduction (D) or Empowerment (E)
RELATIONSHIP SKILLS				
Marital/Partner Relationship (n=668)	20%	75%	5%	D
Sibling Relationship (n=115)	6%	91%	3%	D
Parent/Child Relationship (n=211)	8%	91%	1%	D
Family Relationship (n=895)	11%	83%	6%	D
SKILLS				
Parenting Skills (n=1,892)	8%	86%	6%	E
Vocational Certificate (n=345)	14%	63%	23%	E
Cognitive Development (n=3,756)	2%	91%	7%	E
Social Development (n=3,915)	2%	91%	7%	E
Basic Life Skills (n=664)	13%	82%	5%	D
Physical Development (n=3,372)	1%	91%	8%	E
Educational Skills (n=1,372)	4%	90%	6%	E
Language Skills (n=2,919)	5%	88%	7%	E
OTHER				
Housing (n=175)	21%	58%	21%	D
Clothing (n=223)	44%	45%	11%	D
Transportation (n=1,397)	11%	66%	23%	D
Extended Support Network (n=34)	15%	59%	26%	E
Child Care (n=1,598)	13%	52%	35%	E
Home Management (n=149)	14%	83%	3%	E
Community Resource Usage (n=146)	14%	84%	2%	E
Economic Self-Sufficiency (n=1,036)	18%	76%	6%	E
Social Support Network (n=725)	11%	79%	10%	E
Employment (n=2,019)	18%	57%	25%	E

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and probably grew up in a home where multiple generations have depended on welfare. The process of securing a job often involves several incremental steps that require attitudinal changes about the world of work, the development of a variety of vocational and behavioral skills and self-confidence, and access to child care and adequate transportation. Even then, there may be a need to change jobs several times before achieving an income level that enables individuals and families to be economically self-sufficient.

When interpreting data on full goal attainment, it also should be recognized that families usually set multiple, interrelated goals and that some goals must be met before others can be achieved. For example, it is usually necessary to obtain child care and reliable transportation before one can meet longer term educational and skill development goals and ultimately command regular employment. Also, many deficit goals are, by definition, continual and do not lend themselves to clear goal attainment.

Overall, the findings presented in this section provide evidence of growth in many areas for a large proportion of the CCDP families. Clearly, CCDP has helped families to identify and use community resources and to secure child care, transportation, and improved housing. A variety of health needs (including mental health needs) has been addressed. Goals related to parenting skills, child developmental skills, and education are being met, as are a number of goals related to family relationships. In summary, many families enrolled in CCDP appear to be progressing toward attaining social and economic self-sufficiency.

FAMILIES' SERVICES UTILIZATION

FY 1993 has been a significant year in the life of CCDP. During FY 1993 data collection procedures at the project level stabilized. This increases confidence in the quality and accuracy of the service utilization data being collected and entered into the MIS onsite. As a consequence, the data reported in this section focus on the services utilized by CCDP families during the first half of FY 1993 (October 1, 1992, through March 31, 1993). In addition, families have reached a level of involvement in the program which suggests that they are motivated to actively utilize services. Furthermore, the rate of terminations has stabilized and appears to be decreasing, suggesting that the families are actively participating.

Data presented early in the previous section (in particular, Exhibits 6-2 through 6-4) reflect the type of services received in connection with identified family needs. This section focuses on the number of times each reported CCDP core service was utilized. Services utilized can be classified as either "receptive" services or "active" services. Receptive services include case management, parenting education, developmental screenings and assessments, and home-based early childhood education. These services typically are provided to the CCDP family in the home and usually are initiated by the CCDP staff. Active services are those services that CCDP families actively access either on an as-needed basis or because they involve activities identified in the family's service plan. Active services include center-based early childhood education,[4] health screening services, well-baby care, prenatal care, adult education, material or financial assistance, counseling and rehabilitation services, housing assistance, nutritional assistance, medical payment assistance, and income maintenance.

Included in this chapter are a number of tables (Exhibits 6-8 through 6-22) depicting the patterns of services utilization by CCDP families for both receptive and active services. These tables include the number of families enrolled (i.e., the number of families that could have received the services), the number of families that used each particular service, the percentage of families that used each service,[5] and the average number of services used per family. The child is the unit of analysis for such services as early childhood education, early intervention, child care, developmental screenings and assessments, and well-baby care. For all other services, the unit of analysis is the family, as these services are tracked at the family level.

Receptive Services Utilization

Exhibits 6-8 through 6-11 present data on services that involve receptive utilization (i.e., CCDP projects provide this service directly to all families, usually in their home). Services in the areas of case management, parenting education, developmental screenings and assessments, and home-based early childhood education are discussed below.

Case Management

Exhibit 6-8 following this page presents data on case management services or "activities" received by families through CCDP. As discussed earlier in the report, case management services include needs assessments, planning with the family, review of services received with the family, review and followup with a family's service provider, supportive discussions with the family, translation services, and individual followup. These services represent receptive utilization because CCDP requires that families meet with a CCDP case manager a minimum of two times per month.

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[4] Center-based early childhood education is classified as an active service since the CCDP family accesses this service outside of the home.

[5] Exhibits 6-10, 6-11, and 6-13 presented later do not include percentage information because in Exhibits 6-10 and 6-11, children who receive home-based early childhood education also might be receiving center-based early childhood education and vice versa. The children presented in Exhibit 6-13 are those children who were 12 months and younger during the first half of FY 1993.

Exhibit 6-8

Utilization of Case Management Services[1] (FY 1993)

Number of families enrolled at end of second quarter, FY 1993	2,103
Number of families receiving services	2,076
Percent of families receiving services	99%
Average number of case management activities per family (for first 6 months of FY 1993)	47.9
Average number of case management activities per family (1-year projection for FY 1993)	95.8

[1] Case management services include activities with families such as needs assessment, planning, reviewing services which have been received, meeting with service providers about the family, supportive discussions with the family, and translation services.

Based on these data, 99 percent of the families enrolled during the first half of FY 1993 received at least one case management service, and the average number of case management services received per family during this 6-month period was 47.9, indicating an average of 8 services per month for each family.[6] Although data are not available for the remaining half of FY 1993, we can project that the average number of case management services received per family for the entire year would be 95.8. The high utilization of case management services demonstrates that CCDP projects are in compliance with the program requirement that provides for regular and consistent case management contacts.

An analysis of one specific case management activity—reviewing services received with the family—yields some significant findings regarding the frequency of families' meetings with their case managers. The case manager is expected to review the services received by the family in a face-to-face meeting with the family at a minimum of once every other week. The data indicate that this activity was conducted with 2,011 (96 percent) of the enrolled families, and each family met with a case manager to review services an average of 14 times over a 26-week period. This finding demonstrates that families, on average, participated with a CCDP case manager in slightly more than one case management activity every 2 weeks.

Parenting Education

Exhibit 6-9 following the next page presents data on families' utilization of parenting education services. These data reflect counts of parenting education lessons received in the areas of nutrition, child development, health, and childrearing techniques. The fact that these data are reported on the Family Services Contact Summary Form implies that the parenting education services discussed herein typically are provided in the home through a case manager. Thus, parenting education falls under the category of "receptive utilization" because case managers bring parenting education materials and instruction into the home with them; that is, parents receive the service if they are present for a meeting with their case manager. Parenting education that takes place in classroom settings (data not shown here) entails active utilization, as the parents must participate in the classrooms in order to receive these services. This type of parenting education is almost always recorded on attendance rosters.

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[6] The large difference between this percentage and the 58-percent figure in the impact study may be explained by several factors. As already noted, the process study sample included only currently active families, virtually all of whom were receiving case management services, while the impact study sample included many families who had left the program. Also, process study data were contemporaneous records made by staff, whereas impact study data were parent reports based on recall over a 1-year period. Parents may have failed to recall some meetings with their case managers or may not have defined some contacts as "meetings."

For those families that received parenting education in their homes, the average number of parenting education sessions received for the 6-month period was 10.3 sessions per family. The second row of Exhibit 6-9 presents data that indicate that 1,692 families (80 percent) received parenting education in their homes. Thus, on the average, each family received parenting education in their homes slightly less than once every 2 weeks. The fact that 20 percent of the families were not receiving parenting education in their homes during these two quarters probably reflects the fact that these parents were receiving parenting education in classroom settings. CCDP projects make parenting education available not only through the case managers but also through a variety of parenting courses offered in group settings. If parents already are participating actively in parenting education activities in classroom settings, they may choose not to have their case managers provide instruction on similar topics during their home visits.

Developmental Screenings and Assessments

Developmental screenings and assessments often are conducted outside of the home in a center or classroom, requiring parents to bring their children into a center for this service. CCDP requires that all preschool-age children receive regular developmental screenings and assessments. Consequently, the service involves receptive utilization on the part of families.
Exhibit 6-10 following this page displays data on preschool children's receipt of developmental screening and assessment services. The data indicate that 2,539 (75 percent) of the preschool-age children enrolled in the program received screening and assessment services through CCDP during the first half of FY 1993. Of those children receiving these services, the average number of screenings and assessments received per child was 1.7. This indicates that, with regard to these children, programs are complying with the requirements of one initial screening and periodic followup assessments every 6 months.

The fact that one-fourth of the preschool-age children enrolled did not receive the CCDP-required developmental screening or assessment during the first half of FY 1993 is not a cause for concern, because children who already had received a screening prior to FY 1993 were not counted due to problems accessing this data. In addition, some programs do not adhere to a strict 6-month cycle of conducting ongoing assessments. For example, some children might receive their ongoing assessments during the 26th or 28th week, and in this case, the information would not be reflected in the data for the first half of FY 1993.

Exhibit 6-9

Utilization of Parenting Education Services[1] (FY 1993)

Number of families enrolled at end of second quarter, FY 1993	2,103
Number of families receiving parenting education[2]	1,692
Percent of families receiving parenting education	80%
Average number of sessions of parenting education per family (for first 6 months of FY 1993)	10.3
Average number of sessions of parenting education per family (1-year projection for FY 1993)	20.6

[1] Parenting education services include instruction on such topics as nutrition, child development, and health.

[2] This exhibit includes only parenting education recorded on the Family Services Contact Summary. Additional parenting education could have been recorded for some families on attendance forms.

Exhibit 6-10

Utilization of Developmental Screenings and Assessments (FY 1993)[1]

Number of children enrolled at end of second quarter, FY 1993	3,382
Number of children receiving screenings or assessments	2,539
Percent of children receiving screenings or assessments	75%
Average number of screenings or assessments per child (for first 6 months of FY 1993)	1.7
Average number of screenings or assessments per child (1-year projection for FY 1993)	3.4

[1] Includes focus children and their siblings who were members of currently enrolled families and less than 5 years old during the first half of FY 1993.

Home-Based Early Childhood Education

Exhibit 6-11 following the next page presents data on the receipt of home-based early childhood education for the first half of FY 1993.[7] This service constitutes receptive utilization because no effort is required on the part of families to access the service for their children; it is provided by case managers trained in early childhood education or by a separate early childhood education home teacher on a regular basis during home visits. As shown in Exhibit 6-11, there were 1,614 children receiving home-based early childhood education during this period. For those children receiving home-based early childhood education, the average number of home-based early childhood education sessions received per child was 16.9 sessions,[8] suggesting that, on average, each child received home-based early childhood education more than once every 2 weeks. The average number of parenting education services utilized per family for all of FY 1993 can be projected at 34 services.

Active Services Utilization

Exhibits 6-12 through 6-22 present data for services that require active utilization on the part of families. These services include center-based early childhood education, health screening services, well-baby care, prenatal care, adult education, material or financial assistance, counseling or rehabilitation services, housing assistance, nutritional assistance, medical payment assistance, and income maintenance. The data for each of these services are discussed below.

Center-Based Early Childhood Education

Exhibit 6-12 presents data on the utilization of center-based early childhood education. The unit of analysis for center-based early childhood education is individual children rather than families because the same family could have several preschool-age children who are receiving center-based early childhood education. This type of early childhood education implies active utilization because to receive the service parents must make an effort to arrange for their children's enrollment in early childhood education centers. Although programs have no control over children's attendance patterns, parents can directly affect their child's (children's) level of utilization of center-based early childhood education.

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[7] In Exhibit 6-11, children are the unit of analysis rather than families because the same family might have multiple preschool-age children receiving home-based early childhood education.

[8] Some of these children also receive center-based early childhood education. Further analyses are needed to identify how close 16.9 is to the required number of 24 needed to ensure a weekly early childhood education experience for each child.

Exhibit 6-12 indicates that, in the first half of FY 1993, 2,076 children received center-based early childhood education.[9] This number includes children for whom center-based early childhood education was planned as well as some children who received unplanned, center-based early childhood education because they missed one or more sessions of home-based early childhood education activities. The second row of Exhibit 6-12 indicates that 46.5 days is the average number of days of center-based early childhood education received per child for the first half of FY 1993, which equals an average of almost 2 days per week per child. Because this figure is based only on data from early childhood education attendance forms, it represents an underestimate of the intensity of utilization of center-based early childhood education. If the figure included "early childhood education" coded on the MIS Family Services Contact Summary form (e.g, in the case of a child receiving an unplanned early childhood education session in a center), this figure would likely approach the CCDP requirement of three center-based early childhood education contacts per week.

Health Screening Services

CCDP projects offer a range of health screening services, including medical history; dental screening; disability screening; hearing screening and assessment; HIV (human immunodeficiency virus) screening; mental health screening; nutritional assessment; speech and language evaluation; vision screening and assessment; general physical examination and assessment; and other health screening for specific health problems, such as lead poisoning, sickle cell anemia, and tuberculosis. Receipt of health screening services reflects active utilization because families initiate access to these services.

Exhibit 6-13 following this page presents data on families' utilization of health screening services. The data presented in the second row of Exhibit 6-13 shows that 1,649 of the enrolled families (78 percent) received some form of health screening service. The average number of health screening services received per family was 5.8 for the 6-month reporting period. The average number of screenings for those families which utilize CCDP health screening services for the full FY 1993 can be projected at 11.6. These data indicate that families are making use of the health screening services available to them on a regular basis to meet a specific health care goal or to maintain their health through preventative measures (almost once every month, on average).

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[9] The data presented here are drawn from early childhood education attendance forms and do not include data from the Family Services Contact Summary Form. Additional data on center-based early childhood education could have been recorded on the Family Services Contact Summary Form, but such early childhood education is more likely to be provided by other community centers outside of CCDP.

Exhibit 6-11

Utilization of Home-Based Early Childhood Education (ECE) Services[1] (FY 1993)

Number of families receiving home-based ECE[2]	1,614
Average number of sessions of home-based ECE per family (for first 6 months of FY 1993)	16.9
Average number of sessions of home-based ECE per family (1-year projection for FY 1993)	34.0

[1] Home-based ECE services include sessions with and without a parent present and early intervention education.

[2] There are an average of 1.7 preschool-age children (i.e., under 5 years old) per family. This number represents approximately 2,743 children receiving home-based ECE, because during each home visit the ECE needs of all preschool-age children in the family are addressed.

Exhibit 6-12

Utilization of Center-Based Early Childhood Education (ECE) Services[1] (FY 1993)

Number of children receiving center-based ECE	2,076
Average number of days of center-based ECE received per child (for first 6 months of FY 93)	46.5
Average number of days of center-based ECE received per child (1-year projection for FY 93)	93.0

[1] This exhibit includes only center-based ECE recorded on attendance forms. Additional ECE could have been recorded for some children on the Family Services Contact Summary.

Exhibit 6-13

Utilization of Health Screening Services[1] (FY 1993)

Number of families enrolled at end of second quarter, FY 1993	2,103
Number of families receiving services	1,649
Percent of families receiving services	78%
Average number of health screening contacts per family (for first 6 months of FY 1993)	5.8
Average number of health screening contacts per family (1-year projection for FY 1993)	11.6

[1] Health screening services include medical history, dental screening, disability screening, hearing screening/assessments, HIV screening, mental health screening, nutritional assessment, speech/language evaluation, vision screening/assessments, other health screening, and general physical examination and assessment.

Well-Baby Care

Although all children are required to receive well-baby care, this service involves active utilization because parents need to bring their children to the doctor for their scheduled visits (i.e., CCDP projects rely on the clinics and physicians in the community for the provision of well-baby care to families). At the time of the well-baby care visit, required immunizations are provided to children and routine screenings of hearing, vision, nutrition, or disability are performed for early detection of illness. The standards used for assessing well-baby care and immunization schedules follow the guidelines of the American Academy of Pediatrics (1991). Data on the utilization of well-baby care for children 12 months of age and younger are presented in Exhibit 6-14. The unit of analysis for well-baby care is the number of children visiting a doctor for a well-baby examination.

According to the MIS data, 668 children under 1 year of age received well-baby care during the first half of FY 1993. The average number of well-baby care visits received during this period per child was 1.7. This number suggests that children utilized well-baby care services on the average of almost once every 3 months. However, it is undoubtedly an underestimate of the actual number of well-baby care visits received. Current data tracking problems, where CCDP programs are delayed in obtaining current well-baby care records from children's health care providers, would have prevented a number of cases from being entered into the MIS for the reporting period.[10] Data presented in the final report will provide a more realistic portrayal of the utilization of well-baby services.

Prenatal Care

Exhibit 6-15 presents data on women's utilization of prenatal health care during pregnancy. The standards for assessing prenatal care follow the perinatal care guidelines established by the American Academy of Pediatrics (1991) and the American College of Obstetricians and Gynecologists (1992).

According to completed Pregnancy Description Forms in the CCDP MIS, 271 was the highest number of women who were pregnant at any one time during the first half of FY 1993. CCDP projects are required to make prenatal care available to all pregnant women, but utilization of this service requires active participation on the part of women since it is their responsibility to make and keep scheduled prenatal care visits. According to these data, 190 women (70 percent) were receiving prenatal care during their pregnancy. As indicated in Exhibit 6-15, this level of utilization equals an average of 4.9 prenatal care visits per mother during the 6 months covered by this exhibit. Since the sample included women in the second and third trimesters of their pregnancies, the average figure suggests that these women received an appropriate level of prenatal care.

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[10] CCDP grantees now are being provided with technical assistance on improved techniques for tracking this data from diverse providers.

Several different factors help to explain the finding that 30 percent of pregnant women were not receiving prenatal care. First, this number reflects a data tracking problem, i.e., CCDP projects have had problems in obtaining records of the prenatal visits from the women's prenatal care providers. In these cases, the information would not have been entered into the MIS prior to the end of the second quarter of FY 1993. Second, some women may have given birth quite early on in the first quarter of FY 1993, and they may not have had a prenatal care visit during this quarter. Third, some women may have learned about their pregnancy very close to the end of the second quarter of FY 1993. A Pregnancy Description Form would have been completed for these women indicating that they were pregnant, but the women may not have begun their prenatal care visits.

Adult Education

The category of adult education services includes a diverse range of educational courses, programs, and instruction that require active utilization on the part of families. CCDP projects make adult educational services available to families, but the projects have no requirements regarding an expected level of utilization on the part of families; that is, families' levels of utilization of these services are directly related to their motivation to further their education. Exhibit 6-16 following this page presents data on adult education services received by families during the first half of FY 1993. The following kinds of activities are counted as adult education services:

- Adult health education;
- Education in home management and basic life skills;
- Vocational training;
- Career counseling;
- Job search training;
- Employment services;
- GED training;
- Literacy training;
- English as a Second Language training;
- Remedial education; and
- College courses.

These data are drawn from the MIS Family Services Contact Summary Form and include adult education services provided in classroom settings outside of CCDP as well as those provided by CCDP. Of the families enrolled in the first half of FY 1993, 71 percent accessed adult education services. This number suggests very high utilization of adult education services. The average number for the first half of FY 1993 of adult education sessions attended per family is 6.6 (more than once per month).

Exhibit 6-14

Utilization of Well-Baby Care Services (FY 1993)[1]

Number of children receiving well-baby care	668
Average number of well-baby visits per child[1] (for first 6 months of FY 93)	1.7

[1] Projections for this data were not available at the time this report was prepared.

Exhibit 6-15

Utilization of Prenatal Care Services (FY 1993)[1]

Number of women pregnant at any time during first half of FY 1993	271
Number of women receiving prenatal care	190
Percent of pregnant women receiving prenatal care	70%
Average number of prenatal care visits per woman (for first 6 months of FY 1993)[1]	4.9

[1] Projections for this data were not available at the time this report was prepared.

Exhibit 6-16

Utilization of Adult Education Services[1] (FY 1993)

Number of families enrolled at end of second quarter, FY 1993	2,103
Number of families receiving services	1,496
Percent of families receiving services	71%
Average number of adult education sessions per family (for first 6 months of FY 1993)	6.6
Average number of adult education sessions per family (1-year projection for FY 1993)	13.2

[1] Adult education services include adult health education, home management/basic life skills, vocational training, career counseling, job search training/employment services, training/high school, literacy training, English as a Second Language, remedial education, and college courses.

The average number of adult education services received per family for all of FY 1993 can be projected at 13.2 services.

Material or Financial Assistance

Material or financial assistance provided to families includes provision of the following types of services:

- Clothing;
- Household items;
- Other material goods;
- Emergency funds;
- Child care subsidies;
- School financial aid;
- Small business assistance or loans; and/or
- Low-interest loans.

Exhibit 6-17 following the next page presents data on families' utilization of material or financial assistance services. These services are provided on an as-needed basis, and CCDP projects are not required to provide these services to all enrolled families. It should be noted that families which did not need material or financial assistance during the first two quarters of FY 1993 may have received such assistance at another point during their enrollment in CCDP.

The data in Exhibit 6-17 indicate that more than one-half of the families enrolled received some material or financial assistance services during the first half of FY 1993. Of those families that made use of these services, the average number of times they received assistance during the 6-month period was 3.8.

Counseling or Rehabilitation Services

CCDP projects provide counseling or rehabilitation services to families on an as-needed basis. This category of services includes the following:

- Counseling for alcohol abuse, drug abuse, mental health, nutrition, and family planning;

- Marriage counseling; and

- Family, hearing, occupational, physical, and obesity therapy sessions.

Exhibit 6-18 displays data regarding the number and percentage of families that received counseling or rehabilitation services during the first two quarters of FY 1993. According to the data presented in Exhibit 6-18, one-third of the families enrolled utilized some type of counseling or rehabilitation services during the first half of FY 1993. For these families, the average number of counseling or rehabilitation sessions received per family is 8.5 sessions. These data demonstrate that families which utilize counseling or rehabilitation services do so regularly rather than on an intermittent basis.

Housing Assistance

Housing assistance provided to CCDP families includes the following: temporary housing or shelter, low-rent public housing, rent subsidies, low-income mortgage assistance, home improvement assistance, and utilities assistance (i.e., gas, electricity, oil, and water). Housing assistance is provided to CCDP families on an as-needed basis.

Exhibit 6-19 following this page presents data on families' use of housing assistance and shows that 43 percent of families utilized housing assistance services at some point during the first half of FY 1993. During this period families utilized these services an average of 3.3 times. For the entire fiscal year of 1993, families that utilized housing assistance can be expected to have received such assistance an average of 6.6 times per family over the full year. Families who did not utilize housing assistance services during the first half of FY 1993 may have received housing assistance at some earlier point in their enrollment in CCDP or they may receive it at some point in the future. For many low-income families, housing status can appear to be stable at one point in time, but 6 months later it may be threatened by increased rent, loss of employment, or reduction in benefits. Consequently, various families may have utilized housing assistance services prior or subsequent to the current reporting period.

Nutritional Assistance

Brokering or referral for nutritional assistance is provided to families on an as-needed basis, usually by the family's case manager. Exhibit 6-20 presents data on families who received brokered or referral services from CCDP in order to obtain nutritional assistance. Specifically, the data pertain to referrals for Special Supplemental Food Program for Women, Infants and Children (WIC), food stamps, and other food assistance (such as food donations, supplies, and use of food banks). According to the data in Exhibit 6-20, 1,197 of the families (57 percent) received some brokering or referral services from CCDP for nutritional assistance during the first half of FY 1993. These families received brokered or referral services an average of 4.4 times per family. The average number of instances of brokered or referred nutritional assistance received per family for all of FY 1993 can be projected at 8.8 times.

Medical Payment Assistance

CCDP projects are not required to provide brokered or referred services for medical payment assistance; however, the services are available to all

Exhibit 6-17

Utilization of Material or Financial Assistance Services[1] (FY 1993)

Number of families enrolled at end of second quarter, FY 1993	2,103
Number of families receiving services	1,198
Percent of families receiving services	57%
Average number of instances of material or financial assistance per family (for first 6 months of FY 1993)	3.8
Average number of instances of material or financial assistance per family (1-year projection for FY 1993)	7.6

[1] Material or financial assistance services include the receipt of clothing and household items, emergency funds, child care subsidies, school financial aid, small business assistance or loans, and low-interest loans.

Exhibit 6-18

Utilization of Counseling or Rehabilitation Services[1] (FY 1993)

Number of families enrolled at end of second quarter, FY 1993	2,103
Number of families receiving services	702
Percent of families receiving services	33%
Average number of counseling or rehabilitation contacts per family (for first 6 months of FY 1993)	8.5
Average number of counseling or rehabilitation contacts per family (1-year projection for FY 1993)	17

[1] Counseling or rehabilitation services include alcohol abuse counseling, drug abuse counseling, family planning counseling, family therapy, hearing therapy, marriage counseling, mental health counseling, nutritional counseling, obesity therapy sessions, occupational therapy sessions, physical therapy sessions, smoking cessation counseling, speech therapy sessions, stress reduction counseling, and vision therapy.

Exhibit 6-19

Utilization of Housing Assistance Services[1] (FY 1993)

Number of families enrolled at end of second quarter, FY 1993	2,103
Number of families receiving brokering or referral for housing assistance	894
Percent of families receiving brokering or referral of housing assistance	43%
Average number of instances of brokering or referral for housing assistance per family (for first 6 months of FY 1993)	3.3
Average number of instances of brokering or referral for housing assistance per family (1-year projection for FY 1993)	6.6

[1] Housing assistance services include temporary housing/shelter, low-rent public housing, rent subsidy (private housing), low-income mortgage assistance, home improvement assistance, and utilities assistance.

Exhibit 6-20

Utilization of Nutritional Assistance Services[1] (FY 1993)

Number of families enrolled at end of second quarter, FY 1993	2,103
Number of families receiving brokering or referral for nutritional assistance	1,197
Percent of families receiving brokering or referral for nutritional assistance	57%
Average number of instances of brokering or referral for nutritional assistance per family (for first 6 months of FY 1993)	4.4
Average number of instances of brokering or referral for nutritional assistance per family (1-year projection for FY 1993)	8.8

[1] Nutritional assistance services include WIC, food stamps, and other food assistance.

families who need or request them. Medical payment assistance programs include medicaid, medicare, State programs for special diseases and disabilities, and financial assistance provided for medical care through other means. The brokering or referral activities usually are accomplished through either the family's case manager or another CCDP staff member, such as a core services coordinator.

Exhibit 6-21 following the next page presents data on families' utilization of brokered or referred services to help them access medical payment assistance programs. During the first half of FY 1993, 481 families (23 percent) received brokering or referral assistance to access medical payment assistance programs. The average number of times that families received brokering or referral services from CCDP was 5.2. These data need to be interpreted in the larger context of the timeframe during which families generally receive brokering for medical payment assistance. Many families already may have been enrolled in medicaid when they joined CCDP and have established a relationship with a medicaid liaison; hence, they do not need additional brokering support through CCDP. Other families may have received brokering or referrals for medical payment assistance shortly after their enrollment in the program, particularly since health care is one of the CCDP core services that is supposed to be made available to families immediately. Once enrolled in a medical payment assistance program, such as medicaid, these families would have little need for continued support from CCDP.

Income Maintenance

CCDP projects broker or refer services to access income maintenance for CCDP families. Income maintenance includes Aid to Families with Dependent Children (AFDC); Supplemental Security Income; unemployment compensation; child support; and other public assistance income, such as payments under the Federal Social Security program to surviving children of a deceased parent. The utilization of these services by CCDP families occurs on an as-needed basis. Exhibit 6-22 provides data on families' utilization of income maintenance services. As shown in Exhibit 6-22, 582 families (28 percent) received income maintenance services during the first half of FY 1993. Brokered and referred services aimed at accessing income maintenance services were provided an average of 3.4 times per family. When interpreting these data, it is important to note that some families probably already were receiving an income maintenance service such as AFDC before they enrolled in CCDP. Consequently, these families would not be expected to ask CCDP to help them access additional services.

Summary of Preliminary Results Regarding Needs, Goals, and Receipt and Utilization of Services

CCDP has helped families and family members utilize program and community resources to secure routine and preventive health care, improved housing, nutrition assistance, adult education, and a number of case management services. A variety of health (including mental health) issues have been addressed, educational goals are being met, and many families seem to be headed on a course toward attaining empowerment and social and economic self-sufficiency.

The services utilization data indicate that CCDP projects are meeting the mandates of the Comprehensive Child Development Act, and many families are motivated to use their own initiative to access services available to them in the community. The levels of service utilization presented in Exhibits 6-11 through 6-22 indicate that CCDP projects and families have reached significant levels of stability in the 3½ years of program operation and the 2½ years of providing services to families. As shown earlier in Exhibit 6-8, the provision of case management services has been pivotal to motivating families toward active utilization of services. We expect the data for the second half of this demonstration to provide evidence of continued high levels of service utilization and goal attainment.

CCDP SUCCESS STORIES

In this section a representative sample is presented of true stories that demonstrate how families' lives have been enriched as a result of their participation in CCDP. The stories, many told here in participants' own words, describe families that are achieving success in a variety of ways, including those families that have just begun to experience the small steps to success and those who have made achievements in the face of adversity. Where applicable, each story is prefaced by a description of CCDP goals for the respective component area. Collectively, these stories illustrate through real-life examples the benefits of CCDP to children and their families. Stories are grouped according to the following service areas: child care, early childhood education, parenting education, adult education (GED training and vocational training), health, mental health, and employment. These are followed by stories on participants' experiences in setting goals and in overcoming multiple obstacles to achieve success. Also included are stories on the overall accomplishments of families who are now beginning to enjoy success in different facets of their lives.[11] Through families' letters of support, parents' testimonials, and case managers' narrative descriptions, there is evidence for the kinds of families that value CCDP.

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[11] All names have been changed to protect the identity of the families.

Exhibit 6-21

Utilization of Medical Payment Assistance Services[1] (FY 1993)

Number of families enrolled at end of second quarter, FY 1993	2,103
Number of families receiving brokering or referral for medical payment assistance	481
Percent of families receiving brokering or referral for medical payment assistance	23%
Average number of instances of brokering or referral for medical payment assistance per family (for first 6 months of FY 1993)	5.2
Average number of instances of brokering or referral for medical payment assistance per family (1-year projection for FY 1993)	10.4

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[1] Medical payment assistance services include medicaid, medicare, State programs for special diseases, disabilities, and other medical payment assistance.

Exhibit 6-22

Utilization of Income Maintenance Services[1] (FY 1993)

Number of families enrolled at end of second quarter, FY 1993	2,103
Number of families receiving brokering or referral for income maintenance	582
Percent of families receiving brokering or referral for income maintenance	28%
Average number of instances of brokering or referral for income maintenance per family (for first 6 months of FY 1993)	3.4
Average number of instances of brokering or referral for income maintenance per family (1-year projection for FY 1993)	6.8

[1] Income maintenance services include Aid to Families With Dependent Children, Social Security income, other public assistance income, unemployment compensation, and child support.

Child Care

Child care must be provided to families when requested by a parent who is working or involved in training.

In the following passage, a CCDP project staff member discusses how child care gave a CCDP mother the time and opportunity to work on her goals:

> As a child, Ms. D watched her mother struggle trying to raise her family within the....(AFDC) system. Her mother set a good example by going back to school and getting a degree in nursing. This really impressed Ms. D since she came from a large family and knew the obstacles her mother had overcome to receive her degree.
>
> Ms. D decided that if her mother could make such a positive change in her life, she would follow suit. Ms. D had a son in 1991. After his birth, she worked even harder. When Ms. D was a housekeeper at a local hospital, she had a friend who worked in radiology. Ms. D would visit her friend daily and was very impressed with the work her friend did. Ms. D thought this was something that would interest her and at which she could excel and decided she wanted to go to college to become a radiologist.
>
> Ms. D had been having a difficult time getting everything together when Project B came into her life. During the general assessment, Ms. D made it known that college was what she wanted. Her son was placed in a child development program. This gave Ms. D the time and opportunity to work on her dream. After completing Adult Basic Education classes, she enrolled in the local community college, taking the basic courses needed so she could get into the radiology program.
>
> Ms. D is a now a student who just completed her first year at community college with a 3.75 grade point average (GPA). Her GPA for this past semester was 4.0. She plans to go into the radiology program next spring upon completion of her general courses.

In the following passage, a mother writes about how child care helped her reach her goals:

> In 1989 I gave birth to a set of twins, an addition to five other children of my own. My feelings were those of joy and yet those of distress because I saw myself perhaps another 5 years away from achieving goals designed to gain independence from Government agencies. Since my education had now come to a close due to these most welcome but time-consuming, permanent guests...I threw in the towel. But my thirst for education and independence were not easy

> to forget, yet had to be set aside along with so many other goals and dreams in my past.
>
> Then a wonderful program came to [location stated] entitled Project L. I applied, qualified, and was accepted. My life soon changed from high-tech dreams to high-tech realities.
>
> The program allowed me to pursue my interrupted goals, and my advocate encouraged me to pursue even higher education then I ever had in mind. My advocate has been an asset to my life and those of my twins, who use the day care center while I attend the university. In fact, [for] 2 years in a row now, [I have had] a 3.0 GPA, probably because I know my twins are in the best of possible care with Project L staff.
>
> Yes, Project L was the answer for me—the factor that I needed to help me turn my ever-so-real desire into matter-of-fact realities.

Early Childhood Education

Under the guidelines for provision of core services, all CCDP children under compulsory school age must receive developmentally appropriate early childhood educational experiences.

Many parents have recognized the benefits of early childhood education. In the following paragraphs, one woman describes how this program has helped both of her children:

> Three and a half years ago, Ms. L used to depend on her AFDC check, food stamps, and whatever income her husband brought home. At the same time, Project D came to [area stated], and Ms. L was one of the original program families selected to participate in the project.
>
> "A lot of things have happened since then," says Ms. L, now separated from her husband and raising a family of three on her own. "I remember," says Ms. L, "when my case manager drove me around so that I could get a picture identification and eventually my driver's license." Last year, using her tax refund, Ms. L purchased her first vehicle. Working full-time as a waitress at a popular restaurant while being the sole provider of her household, Ms. L has had to overcome many challenges. Her 6-year-old was diagnosed with a speech impediment. With the support of Project D's staff, Ms. L spent lots of time coaching and encouraging her son to speak and read out loud. Now, almost 2 years later, Ms. L is happy to report that her son can read and speak "normal" at his level and is eagerly awaiting to start first grade this fall.

> Ms. L's daughter, on the other hand, only 3½ years old, seems to be slightly ahead of other kids in the same age group. "A lot of that progress," says Ms. L, "can be attributed to the early childhood activity that we do with the case manager on a weekly basis." Ms. L's daughter will be enrolled in Head Start this fall.
>
> "As I look back," says Ms. L, "besides the child care and medical copayments, Project D has been instrumental in the last 3 years in helping me to achieve what I have today." Ms. L's latest goal is to purchase a trailer with a bedroom for everyone—a place they can all call home.

Another woman wrote this letter, attributing her 2-year-old son's strong emotional and cognitive development to the early childhood development activities:

> I have been in the program for 3 years, since my son Sam was born. I cannot begin to list all of the positive effects on my and my family's life that CCDP has had. First of all, the benefits my son has had from CCDP are overwhelming! Because of CCDP, my son Sam has had access to developmental toys and games and learning tools that children who are not in the program are not exposed to. Because of this, Sam has grown emotionally, cognitively, and is very self-assured. He is a wonderfully smart 2-year-old. He knows his alphabet and counts to 20. He also is beginning to write his letters and numbers. For his age, he is smarter than the average 2-year-old. This, I am positive, is because of the early childhood development program of CCDP. I have three other children who are older than Sam and none could do the things that Sam can do at [age] 2. And as Sam's mother, the childhood development specialist who comes to my home "teaches" me to "teach" Sam. As a mother of three before Sam was born, I thought I knew it all on how to be a good parent. The CCDP project taught me how wrong I was. Thanks to CCDP, I am learning how to teach Sam and help him grow.
>
> I want other people to be able to experience the kind of success I've had because of being involved in CCDP. Everyone deserves this kind of chance in his/her life. Every child should have the opportunities that Sam has had in CCDP. I think CCDP is one of the best programs this country has, and I think it should be continued indefinitely.

Parenting Education

The CCDP parent education component includes instruction in child development, childrearing, and health care as well as nutrition counseling and basic life skills.

The following two passages were written by CCDP participants from two rural projects. Each discusses the importance of the parenting education portion of his or her experience with CCDP:

> CCDP has made a great difference in our lives. The program has taught us how to deal with family problems and issues. Also it showed us new ways of disciplining and dealing with family pressure. Sometimes we come from dysfunctional homes as children, and we need to learn how to raise healthy children, mentally and physically.
>
> Our child development specialist has taught us many ways to make toys, to get back to [the] basic skills our kids need, to use what [we] have in our homes, and to deal with the many situations that come up. Also, our family development specialist has helped a great deal with making us use our heads on adult affairs. Family life is very stressful when you have so many complications to start off with. You guys helped us through a lot.
>
> Also, everyone we have worked with has made us feel like we are people, not just statistics. We can change our lives if someone shows us how, and I feel CCDP could help a lot of people. We also have made new friends through parent meetings, [the] advisory board, and parent council meetings. Everyone is so helpful and treats us as equals. I feel very fortunate that we have had the opportunity to be a part of CCDP. I pray this program continues. There are a lot of people needing the help, support, and knowledge that CCDP gives.

The second passage is as follows:

> I am writing in regard to Project X. My children and I have been involved [in CCDP] now for 3 years. We have learned through trial and error different approaches to being a family. We have had a lot of experiences meeting new and different people. I myself have gained quite a bit of knowledge pertaining to parenting, education for myself and [my] children, nutrition, self-esteem, and health.
>
> My children look forward to their weekly visits. I cannot tell you how much we have gained through this project. I know there are a lot of families that could benefit from Project X in the future. The specialist that comes to my home is more than just a specialist, she is a friend, someone I can always count on to make my day. I, for

> one, can say Project X has been and continues to be an important part of my and my family's lives. Keep this project around. It really does help physically, emotionally, financially, and socially. We always will remember the fun we have had and the things we have learned. Thank you.

The following passage was written by an urban CCDP project staff member. The passage describes a Haitian immigrant family and how the parenting education portion of CCDP was a vital part of the family's CCDP experience:

> Ms. M and her husband, Mr. P, are Haitian immigrants. They speak Creole, a derivative of French. English is their second language. Mr. P is more fluent in English than his wife because he has been in this country longer, attended....ESL classes at night, and benefited from exposure to the language by being the family's breadwinner, always working or trying to find work.
>
> Ms. M on the other hand was at home, caring for their children, ages 4, 3, and 1. When we enrolled the family in Project M, Ms. M was expecting her fourth child. That child is now 2 years old. The 4-year-old was attending special education classes to improve his language skills. The 3-year-old later followed in the same path. This problem was the result of the lack of communication between the parents and the children. They were not aware of the need for verbal stimulation in the development of a child's speech. They thought they just had to wash the children, feed them, and take them to doctor appointments. When I suggested that she speak to them, Ms. M's reply was: "What do you tell them? They can't speak, and they don't understand." Interaction with the children heretofore simply did not occur. One child was enrolled at [location stated] at age 1, and the youngest started receiving early childhood education at 3 months [of age]. Ms. M was encouraged to attend ESL classes and parent support groups at the center. Ongoing discussions and information about child development and the nurturing program have helped her understand and manage the children's behavior. She is now able to communicate better with them and is using spanking much less as a method of discipline.
>
> Ms. M no longer needs a translator. She can access services in the community. She recently attended an [English-language] nursing assistant program and succeeded. She is now looking for employment. The decline in the job market has made her efforts difficult but has not affected the sense of pride she is enjoying since she earned the certificate.
>
> She is very thankful for the support she receives from the program. We believe Ms. M has come a long way; she is to be commended for her efforts and success.

Adult Education

CCDP projects provide for a wide array of adult education and vocational training programs to assist families in meeting their economic and self-sufficiency goals.

The following passages detail the stories of participants from different projects and their education goals, all told from the vantage point of CCDP project staff:

> A mother enrolled in Project Q in March 1990 with children ages 1 and 3 and was expecting another child. She was receiving AFDC at that time. During 1992 she attended GED classes, Family Start Nurturing Sessions, and an Office of Employment Development workshop, as well as enrolled in an alternative high school program that gave her further GED training and placement as a volunteer in a facility for the elderly. In January 1993 she passed the GED exam. She then secured part-time work and has since secured full-time work. Finally, she secured financial assistance to begin college in September 1993.

The second passage is as follows:

> Upon entry into Project S, a single mother of one infant son was living with an aunt and several other family members. Her income supports included AFDC, food stamps, and medicaid. She was enrolled in high school, and she graduated during her participation in the CCDP. Through determined advocacy on the part of Project S, she was accepted at a local university where she majored in psychology.
>
> With the help of the program, this young mother, who had never lived independently, acquired furniture and moved into Section 8 housing. She successfully completed 2 years at the university. She now is married and has completed certified nurse's assistant classes. She is employed, and her son is in licensed day care. Her husband is a day-shift manager with health insurance benefits. The family is not receiving public assistance of any kind and presently is applying for a loan in order to purchase a home.

The third passage is as follows:

> A single mother of an infant daughter was living in a dysfunctional family with her mother and stepfather when she enrolled in CCDP. Her income supports included AFDC, food stamps, and medicaid. She was enrolled in high school where she maintained a high GPA. After entering Project S, she moved into independent housing with

> her child's father. She completed high school and received nurse's assistant certification.
>
> With the help of her case manager, she enrolled in a local university where she currently is a sophomore majoring in nursing. The father [of her child] is employed, and she works part-time during the academic year and full-time during the summer months. She receives financial aid for college, but the family is off all other public assistance. They have even been able to purchase a car. The mother and father share the responsibility of parenting and both use positive parenting strategies acquired from Project S. The child, who was [born] 3 months premature, shows no signs of developmental delays and is in licensed day care.

The fourth story is presented below:

> The family has both Native American and African-American roots. All family members were born in the United States. When the family first enrolled, neither one of the parents had received a high school education. The father, Mr. L, did not think he needed to enroll in the program and refused to do so. He stated that he was doing just fine the way he was and refused to participate.
>
> When the mother, Ms. F, first enrolled in Project D, the family was 100-percent dependent on subsidies. None of the children had received immunizations or physicals. With a great deal of assistance and prompting, after 1 year in the program, Ms. F slowly began to open up and start participating in the program. She slowly began to work with the advocate on the child development issues. She began to take her children for physical and immunization appointments. The children are now caught up on all of their immunizations and consistently have kept all of their health care appointments. Ms. F also began to take an interest in obtaining her GED. She eventually signed up for GED classes.
>
> After seeing his wife excited about the program, Mr. L decided to enroll in the program. He began attending GED classes with his wife and slowly began seeking employment. Project D assisted him in obtaining part-time employment, which now has turned into full-time employment. He also has become insured through his employment.
>
> Ms. F has worked hard on her GED and has become actively involved with the parents council and in child development with her advocate. She also has been a part of the volunteer training through our agency. Ms. F received her GED, and Mr. L will have his GED in 30 days. The family is now only 50 percent dependent on Government subsidies and is looking forward to the day when it will not have to depend on Government subsidies at all.

> Ms. F is planning on enrolling in a community college to obtain a social service degree. She plans to go and help her Native American community. She has stated that she specifically would like to help other families in the same way Project D has helped her.

The following story describes the current and upcoming educational successes of both a mother and her daughter:

> Ms. R, primary caregiver upon enrollment, was receiving unemployment benefits after having been laid off from a secretary's position. She resided in a two-bedroom apartment and was pregnant upon first receiving services from the project. Ms. R had an extremely difficult pregnancy and needed home health care services throughout. She participated in support groups and other activities with Project M. Ms. R completed several positively progressive service plans that eventually allowed her to access better housing in a suburban setting, and she has completed an application for full admission to college.
>
> Ms. R's daughter also made some significant accomplishments. Ms. B, a fifth grade student in the public school system, won a contest which involved tracing an invention back in time and then developing that invention for use in the 21st century. Ms. B chose to write her essay on the umbrella. She researched back to the days when women carried parasols as a fashion statement all the way up to the many shapes and sizes in today's world. Being a very intuitive young lady, she invented a watch which would have a small button on it. When one presses the button, he/she would be encapsulated by a plastic bubble. This would protect one not only from the rain but from all of the elements and pollutants in the environment.
>
> As recipient of first place in the essay contest, Ms. B received $500 in spending money and a trip to Washington, D.C., for her entire family. Most importantly, however, Ms. B was awarded a $10,000 scholarship for the college of her choice in the 21st century.

Health

Each project has developed a model for delivery of health care services that includes provision of prenatal, routine and acute care, health screening and assessment, and immunizations and other preventive care.

Following are success stories of families in the area of health:

> Last year, life seemed overwhelming to Ms. C, a 23-year-old single mother. Her 4-year-old was fighting and disrupting the family at every turn, and she was troubled because her 3-year-old didn't seem to be

> developing at a normal rate. Then her infant son had to be hospitalized for malnutrition because he wouldn't eat. "I was losing confidence in my ability to be a mother," Ms. C said.
>
> Project G pulled together a team of professionals, including physicians, nurses, dietitians, counselors, and school officials, to help Ms. C cope with the problems in her family. In-home nurses taught Ms. C to feed her baby through a tube in his stomach. Pediatricians discovered that Ms. C's 3-year-old had a serious hearing problem that prevented him from responding to the world around him. And after extensive evaluations, it was determined that Ms. C's 4-year-old needed the extra attention provided by a local child care center serving children with special needs.
>
> Eighteen months after Project G entered Ms. C's life, the young mother no longer feels out of control. Her youngest is now a healthy toddler, running and playing like other children. Thanks to a new hearing aid, her middle child talks constantly to his mother and brothers. And her oldest child's behavior is improving every day.
>
> But Project G isn't quite finished with Ms. C and her family. Counselors have persuaded Ms. C to begin work on a GED so she can eventually qualify for a job that will enable her to give her family a better life.

One father tells how CCDP has met his special medical needs and served the needs of his family as well:

> My family has been involved in Project X since 1991. The project has been of enormous benefit in our lives. I have been on worker's compensation due to a spinal injury since September 1989 and am just finishing retraining in the field of mechanical drafting at a technical college. Due to Project X, my wife Ms. J also has been able to complete a culinary course at the same school. Project X provided day care funding so that my wife could attend school full-time, riding with me to school. She completed school in less than the usual required time because she didn't have to worry about the kids and could devote 100 percent of her attention to school. She plans to attend college in fall 1994 to pursue a degree in hospitality and tourism management. This is due in part to the continuing encouragement and support from the Project X staff. Because my condition is not going to improve and will slowly worsen, she will likely become the primary wage earner in our family in the years to come.
>
> We have had very good experiences with Project X. I believe that it could serve as a model for welfare reform. Providing help on a client-need basis versus a cut-and-dried formula with very little contact or interaction would be a vast improvement in guiding

> families toward independence and self-sufficiency. The weekly home visit by Project X staff is something we really like. The kids look forward to each visit and the different activities we do together. We also get a lot of helpful information from the age-appropriate materials on child raising that we get regularly. We have Healthy Start for the kids but no health insurance for us, and Project X has provided funding for our necessary visits to the doctor and dentist. Without their help, we just could not have gotten the health care we needed, and I would have very likely wound up becoming critically ill when I developed pneumonia 2 years in a row.

Mental Health

Mental health support is provided at all sites. These services include therapeutic mental health services, such as individual and family therapy and marital counseling, as well as preventive mental health services designed to motivate individuals and raise self-esteem. Projects also provide substance abuse treatment services either onsite or through agreements with drug and alcohol treatment centers, health centers, and alcohol rehabilitation centers.

The following passage was written by a CCDP staff member at one of the urban project sites and notes the motivational help a CCDP participant received:

> Ms. P was referred to the mental health coordinator due to stress from being unemployed. She stated that she felt hopeless at times and wanted to give up. She participated in a series of discussions with the coordinator, family educator, and case management supervisor. After working with the mental health coordinator for about 4 weeks, Ms. P eventually found a job with a reputable employment agency where she worked on a temporary basis. She continued to receive support from both the mental health coordinator and the family educator. She was offered a permanent position with the firm.
>
> Ms. P continues to receive services for her family and herself and often expresses her appreciation for the effort and confidence that the staff placed in her in motivating her to continue to hang in, even when she gave up on herself.

The following passage told by a CCDP staff member discusses a mother who came to CCDP with drug abuse as the source of ongoing crises in her life and the lives of her children:

> When Ms. N joined Project J, she had three sons, all developmentally delayed, was pregnant with a fourth, lived in Government housing, and was an AFDC recipient.

> Ms. N confronted her addiction in one of her family advocate's bimonthly visits. With Project J's assistance, she entered inpatient substance abuse treatment. Ms. N's recovery is a success story in itself. She's been off drugs for 15 months with no relapses!
>
> Drug-free, Ms. N's life has blossomed as she has aggressively pursued a series of positive steps for her family. Working toward her goal of becoming a physical therapist, she obtained her GED and has completed her third semester of courses at a local community college.
>
> Soon Ms. N will celebrate 1 year of marriage. She and her husband have purchased a home across the street from her children's elementary school. The boys have received special attention and are progressing well developmentally.
>
> Ms. N works full time with [location stated] and is active in her church. Her husband works full time in the bakery of a local retirement community.
>
> The couple attends all Project J activities. They continue to consult their case manager on issues such as increasing Ms. N's husband's educational level, time management skills, and budgeting.

A large part of the mental health component of CCDP is to heighten participants' self-esteem and motivate them to want to achieve their goals. The following passage, written by a CCDP staff member, tells of a parent's successes in this area:

> Success can be measured in many ways—for some, [it is] financially, and for others [it is] in far less tangible emotional strength, increased self-esteem, and a reversal of depression. For Ms. Q, these less tangible indicators are remarkable. When she signed up for the program, she had just had a child, been deserted by her boyfriend, and, as a result, lost most of her household goods. [She] was so depressed she could barely speak. Her self-esteem was at an all-time low, and her interest in life was nonexistent. Slowly, through consistent and persistent support, she and her case manager began talking about her future and that of her children, and she once again saw beyond the morass of her personal life.
>
> Ms. Q, with her case manager, began to embark on several months of career exploration and goal planning. She took her first big step by entering the Job Opportunities and Basic Skills (JOBS) program. Upon completing the Life Skills and Academic Remediation programs offered through JOBS, she decided to enroll in a secretarial training program. Once again barriers presented themselves, but together Ms. Q and her case manager plotted her path to the training site some two buses and 45 minutes away—and she was on her way to her own personal success. At graduation, Ms. Q was given five

> awards, including perfect attendance, and celebrated her achievements with her daughter, her case manager, and our community organizer. She is very proud of her accomplishments, which translates into a strong sense of self, a light-hearted spirit, and a "can-do" attitude that will serve her well in her imminent work life.

Employment

Employment services are crucial to many families enrolled in CCDP. Each project is responsible for developing, planning, and monitoring employment services.

In the following passage, a father discusses how CCDP helped him find employment:

> Project A has helped in getting me better employment. My new job is more fun, has more security, and has much better benefits. Project A also has helped our family's self-esteem, making us a much better family with each other. It has showed us so many different resources in the community. And now it is helping us with our budgeting and getting old, big bills paid. Project A is such a good program. I don't know where we'd be without it. Probably not together, and our young boys would probably be headed for trouble like our big boys have been. Thanks.

The next three passages detail the stories of mothers from three different projects who have succeeded in fulfilling their employment goals:

> Ms. A enrolled in Project K as a single parent with two children, living in a one-bedroom apartment. [She had] parenting and nutritional concerns, [was] receiving AFDC benefits, [was] getting her medical care at the [place stated], and [was] in serious debt. Ms. A and her case manager outlined a very detailed program for herself and her family. Project K pays her child care expenses and has provided many hours of parenting and nutritional education. Her training and experience has led to a full-benefits position at a legal firm, which now pays almost $36,000 a year. She lives in a large, two-bedroom apartment and has systematically paid off all her debts.

The second story is as follows:

> A mother enrolled in Project Q in August 1990 with two children. Her oldest child is 5 years old. The focus child will be 3 [years old] in August of 1993. She recently delivered a 7-pound baby girl on May 19, 1993.

> During her enrollment in Project Q she has been able to secure employment as an assistant administrator with a local newspaper. She has been working there for almost 3 years. She was able to obtain a driver's license and purchase a car in 1993. She was able to arrange for licensed child care for her 3-year-old and newborn daughter. The father of her children also was able to acquire employment through the assistance of the employment coordinator.

The third story is presented below:

> Ms. B is a 35-year-old, African-American, single mother of a 2-year-old daughter. At the time of her enrollment into Project M, Ms. B was unemployed and receiving public assistance through AFDC. Since participating in the program Ms. B has made great strides and has accomplished much. In the beginning Ms. B appropriately utilized Project M's support services by participating in the women's support group. She also used Project M's drop-in center for her then 1-year-old daughter while she actively sought employment.
>
> Ms. B always has been a woman of great pride, and her first goal was to become self-sufficient through meaningful employment. Three months after her enrollment in Project M, Ms. B obtained a part-time position with a private social service program. Because it was a part-time position and her income level was minimal, Project M helped Ms. B subsidize family day care. Three months after beginning her employment, Ms. B was offered a full-time position with the same agency.
>
> Through the support of her case manager, Ms. B was referred to the Department of Public Welfare for a day care voucher. She was accepted into the program and was allotted day care vouchers for 1 year. As a result, her child is actively participating in center-based day care and is thriving developmentally and emotionally.
>
> Although Ms. B found employment shortly after her enrollment, she continued to use the support and encouragement provided by Project M. Through the aid of the drop-in center, parent support group, subsidized day care and emergency funds, Ms. B was able to achieve her goals. Her employment has reinstated her self-worth and has given her the confidence to succeed.

In the next story, a parent's employment history is discussed:

> A participant attended the first career and education fair in April 1992. With the promise of employment, she showed up with several copies of her résumé. She was connected with the Public Service Company, which is represented on the community advisory board. Through discussion with the company's treasurer and director of

> personnel, this participant obtained employment. Coincidentally, she ended up in the treasurer's office. Her first position was entry level, and she expressed her desire to move to a more challenging position. She was able to accomplish this relocation within 1 year of employment. This participant continues to be active in parent meetings at Project H and recently has become involved in community activism. She may possibly become a representative from her community to a nationwide conference in Oakland, California.

Goal Setting

Case managers are responsible for building relationships with the families and provide, coordinate, and/or monitor the services that are necessary to carry out a set of goals established by the family.

Goal setting is an important component of CCDP. In the following passage, a staff member discusses how a young couple learned to take the smaller achievable steps to success:

> When Mr. S and Ms. O joined Project J, they needed immediate resources for an array of problems: health, housing, employment, and planning. They were living with their 2 daughters in a small house with 2 other families—12 people, including an abusive alcoholic—and were crowded into very tight quarters [which made for] a difficult and volatile setting.
>
> According to Mr. S and Ms. O, they did have goals, but somehow they kept getting lost along the way. Mr. S had trouble holding a job. Since he spent very little time with his daughters, parenting was left largely up to Ms. O.
>
> They felt that they needed to slow down, that perhaps their efforts were too hurried or misdirected. With Project J's help, they learned to break down the larger goals into smaller, achievable steps.
>
> First, they enrolled their children in Project J's child development program. Ms. O began attending classes at a community college. Later, she was hired by the Red Cross as a full-time employee. Ms. O now works as a family advocate for a local social service program. Mr. S's employment has stabilized and he has become more actively involved with his daughters.
>
> Mr. S and Ms. O bought a house this summer. They're setting new goals and working toward them one step at a time.

Below a young mother discusses her goals:

> I would like to tell you how wonderful Project X is. Project X has been involved with my family for 3 years now. It has changed my life. When I first met [project staff named], I had no control over my life. I thought everything was hopeless. Through the years, [staff member name] has helped me get back on my feet and move in the right direction. Project X has helped me feel confident in my decisionmaking. They always let me choose what to do next.
>
> [My case manager name] showed me the resources for locating and paying for child care while I worked and went to school. She helped me with the paperwork for school. [My case manager name] helped me become aware of my ideas for the future and put them on paper. Realizing I had goals and that I could take time to reach them helped me to take charge of my life.
>
> [My case manager name] has gone to and organized meetings for my son. These meetings helped me understand his condition and understand him. The project's information on parenting helped me to understand children and what to expect.
>
> The project has opened a new door for me and my children. I am trying to become an employed, educated parent, and I now have the confidence to do what it takes. Before I became involved with the Project X, I didn't care if I worked or not. Now I want to work and go to school.
>
> Thank you for letting Project X help me.

In the following statement, a parent itemizes the goals and successes her family has experienced as a result of participating in CCDP:

> Project A has helped us set goals and accomplish them, such as:
>
> 1. Studying to get a better paying job;
> 2. [Training to] become more assertive with bosses and agencies;
> 3. [Training to] become assertive parents versus controlling parents;
> 4. Learning better ways to pay for housing (e.g., to get off the Farm Home Loan [and on] a 15-year loan);
> 5. Attending child development [training], including what is appropriate for what ages and what children should know at certain ages;

> 6. Using self-talk and affirmations to say "I can do this" versus "Maybe I can";
>
> 7. Working out a budget to finish two bedrooms and paint our home;
>
> 8. Planting and keeping up the garden;
>
> 9. Staying current on dental and medical needs;
>
> 10. Finding an agency that helped us weatherize our home;
>
> 11. Attending classes on job searching and talking to different interviewers, [which] helped us become more aware of interview success when searching for a job;
>
> 12. Attending communications classes;
>
> 13. Attending parenting classes of all kinds; and
>
> 14. Attending budgeting classes.

Overcoming Multiple Obstacles to Success

The following scenarios are just a few examples of the multiple problems families often have to overcome in order to succeed. The first scenario is as follows:

> As one of the original program families, Ms. J has never lost sight of her dreams as she battled substance abuse, psychiatric problems, and a very poor self-concept due to facial scarring from a car accident and a very severe scalp disease. After successfully completing the parenting curriculum, she completed her GED. This success, coupled with her new parenting skills, sparked an interest in further training. She has completed the [Child Development Associate] credentials through a local day care provider and now is employed as a day care teacher with the Head Start program and also works part time for various private day care providers. Ms. J now is enrolled in college for the fall 1993 semester, with aspirations of a career in the medical field.

The second story is as follows:

> Sometimes the [people] we love equate [our] success with losing [us] and fight our achievements every step of the way, and Ms. T was no exception. Fortunately, persistence and determination are a major part of her personality and these characteristics held her in excellent stead. Ms. T, with the support and encouragement of her Project N case manager, struggled against the barriers of domestic violence, inadequate transportation, and inaccessible day care in order to

reach her training program, which was two bus rides and 1 hour away from her home. When all formal systems failed, Ms. T's case manager drove her and the boys to day care and the bus stop.

Supported and encouraged, Ms. T finished her program with honors. Unfortunately, just after graduation the training program lost funding and could not help her find a job. Ms. T's excellent skills and Project N's opening of a few doors landed her a short-term job working for the community health center. During this time she continued to build her skills and to seek a position on her chosen career path. She worked on interviewing and other job search skills with her case manager and the administrative coordinator.

Finally, in part as a result of a job lead and recommendation through Project N, Ms. T's skills landed her the kind of position she truly desired. In addition to earning excellent work evaluations as well as the respect of her supervisor and coworkers, she has since finished a certificate program for computers at a local college. She plans to begin a 4-year bachelor's degree program in the near future.

A Multitude of Accomplishments

Several CCDP families have accomplished their goals for continuing their education, gaining meaningful employment, and raising healthier children. Below is the story of a young parent who sought to get off welfare:

> Ms. V became one of the service families for Project I in July 1990. She was 16 years old, single, and pregnant. She had dropped out of school in order to have her baby. She reentered school for a few months and then entered a community education program for completion of her GED. After finishing 1 year, she made the decision to look for a full-time job rather than continue with school.
>
> In February 1993, Ms. V was hired into an 8-hours per day, 40-hours per week position. She continues to work, with an excellent attendance record. She enjoys her job and looks forward to going [to work]. She is dedicated to long-term employment.
>
> As of June 1993, Ms. V no longer receives AFDC benefits. She continues to receive a small amount of food stamps. Her company provides health benefits for her and her daughter. While Ms. V is at work, her 2-year-old daughter is being cared for at a day care home. Her daughter is progressing very well developmentally, and Ms. V realizes the importance of having her daughter at a well-supervised child care home.
>
> Ms. V has been successful in reaching her goal of "getting off welfare." She is proud of her work record and plans to complete her high school education by taking night courses as soon as possible.

The following summary of one woman's experience is typical of many CCDP families that have accomplished their goals:

> Since entry into Project S, [she] has completed high school, received her community needs assessment certification, and enrolled at the State university where she currently is classified as a sophomore.
>
> She moved with the focus child from her mother's dysfunctional home into independent housing with the focus child's father. The two share responsibility for parenting and are both excellent parents. He supports the family [by working in a] factory. She works part time to supplement the income. The family is off of public assistance. She does receive financial assistance.
>
> The focus child, who was born 3 months prematurely, displays no developmental delays. The child is in licensed child care.

The following success story, told by a case manager, demonstrates how one family has turned itself around after taking advantage of CCDP services and committing itself to creating a better life:

> Ms. C was enrolled in our program from the start. She was receiving AFDC and sharing an apartment with another girl to make ends meet. When her baby turned 1 year old, she decided to work toward her GED. She took and passed her GED test. She now has started at a technical vocational institute and is working toward certification as a legal assistant. This summer she will be training with a lawyer's office. She will graduate in December from the institute. Currently she is enrolled in the FSS program with the city's housing department and now is living on her own. She wants to continue her education at the local university. Her son is attending the university's child care center.
>
> When I began working with this family, the primary caregiver was a homemaker with a new baby. Her husband was looking for full-time employment; he had a part-time job as a car painter's assistant. The family quickly seized the opportunities that CCDP offered and pursued its goals of education, better employment, child care, and parent education.
>
> There were a few setbacks in the beginning: the husband lost his part-time job, child care providers were not dependable, and classes were full or unavailable. The family fell behind in its financial responsibilities.
>
> Eventually all of these problems were resolved. [The woman's] husband enrolled in a course at a community college in emergency technician training. He did not find employment in that field immediately, but he knew where he wanted to work, and he applied

> for any open position that was available. He was hired at a major hospital as a shuttle bus driver. Without giving up hope for a better job, he was hired on as a rehabilitation technician and received full-time, permanent employment. Since then he has envisioned goals of better employment and now wants to become a fireman.
>
> Because he is only 20 years old, he was unable to apply for any paid position with the city fire department, so he became a volunteer fire fighter, once again beginning at the bottom. During this time he has remained employed at the hospital.
>
> The family has purchased a home and bought a new car. Through the help of our employment coordinator, the primary caregiver has been able to move from a minimum wage job in sales to a full-time permanent position as a bank teller.
>
> The focus child regularly attends a CCDP child development center. His developmental assessments and screening show that he is developing at above the normal range.

This concludes a discussion of the needs and goals of CCDP families, the services received by CCDP families to help them meet their objectives, and the success stories of a few of the families that have been helped by CCDP.

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Chapter 7. COMMUNITY EFFECTS

This chapter discusses preliminary analyses of the effects of the Comprehensive Child Development Program (CCDP) on communities. Several sources of qualitative data were used in order to portray the depth and magnitude of the effects that CCDP has had in each community. This chapter includes commentaries regarding the effects of CCDP from CCDP advisory board members and CCDP project directors, as well as from ethnographers' reports. The community-level process outcomes discussed in this chapter are indicative of CCDP's potential to facilitate improved coordination of community services. This is a potentially important discovery, especially in light of the importance that services integration plays in ensuring that quality comprehensive services are provided to families with multiple and complex needs.

METHODOLOGY

This chapter includes analyses of three sources of qualitative data regarding the effects of CCDP on the community. The data were examined in order to reveal the patterns, themes, or categories of analysis that emerged from the data rather than being imposed on them prior to data collection. In other words, the goal of the analyses included in this chapter was to search for natural variations in the data on community effects (Patton, 1990).

Because qualitative methods produce detailed information about a small number of individuals or cases, the validity of qualitative analyses is reduced relative to that yielded by quantitative methods. One method of increasing confidence in the validity of qualitative data is "triangulation" or "corroboration" (Bryman, 1988; Rossman and Wilson, 1985). Triangulation involves the utilization of different methods, or sources of data, to test the consistency or validity of findings. Assessing the degree of convergence of findings from multiple perspectives on the phenomena of interest can result in an improvement in the accuracy or validity of conclusions.

In this chapter, three sources of qualitative data are discussed: (1) CCDP advisory board statements, (2) CCDP project directors' statements, and (3) ethnographers reports. The data from each source were subjected to content analysis, a commonly accepted qualitative data analysis technique (General Accounting Office, 1992). Together, these 3 perspectives provide the reader with a multilayered understanding of the complex ways in which CCDP projects influence and are influenced by the communities in which they operate. The procedures used to collect these 3 sources of data are presented next.

Advisory Board Statements

Advisory boards are an important source of support and advocacy for community-based organizations such as CCDP. Although advisory boards are composed of community leaders from a variety of backgrounds, board members have certain goals in common, such as facilitating the implementation of a project, fostering a project's continued organizational and fiscal development, and finding new resources for serving families. Whereas the specific functions of CCDP advisory boards were not legislatively mandated, the composition of each board was legislatively mandated to include CCDP family members; public and community service providers; and political, educational, and business representatives.

CCDP project directors were asked to solicit written statements from their advisory boards regarding the impact of CCDP on families and the community. Advisory boards were not given guidance as to the specific content or format of these statements. A content analysis of these statements was performed in order to discern major themes and topics.

Project Directors' Statements

In the spring of 1993, project directors were asked to provide information from a variety of sources (e.g., newspaper articles and project newsletters), as well as their own perceptions about the impact of CCDP on their communities. This material was content-analyzed in order to reveal common themes. All project directors responded to the request for information.

Ethnographers' Reports

In late 1990 ethnographers were asked to describe the nature of the community service network that existed prior to and 1 year after the implementation of CCDP (reports were completed by February 1991). Ethnographers examined the following issues:

- Relationships between and among service agencies serving low-income families prior to the start of CCDP;
- Changes in relationships between and among service agencies since CCDP; and
- Current coordination/interaction among CCDP-involved agencies, as well as what facilitators and barriers exist.

The ethnographers used numerous methods to gather this information, including unstructured and semistructured interviews with CCDP senior staff, line staff, advisory board members, and families; participant observation; and analysis of project and community documents. The main focus of the ethnographers' reports was to attempt to determine the early impact CCDP may have had on the community services networks.

In 1992 ethnographers were asked to evaluate how services integration efforts had changed and developed over time. Ethnographers also discussed the facilitators and barriers to services integration in their communities.

Future ethnographer reports will summarize CCDP projects' effects on service integration at the service and systems levels over the full course of the CCDP project. The final report will include a complete analysis of these reports.

RESULTS

Content analyses of advisory board statements, project directors' statements, and ethnographers' reports revealed three major themes regarding the positive impact of CCDP on the community: (1) CCDP influences on services integration in the community; (2) CCDP influences on families access to and utilization of services in the community; and (3) CCDP influences on grantee agencies. Information on the first theme was gleaned from all three data sources, whereas information on the last two themes was drawn from CCDP advisory board and project directors' statements. A discussion of each of the themes, supported by illustrative statements or quotes, is presented next.

Influences of CCDP on Services Integration

Although services integration is not an explicit goal of CCDP, the conceptual underpinnings of the CCDP design include an implicit focus on activities that theoretically could lead to improved coordination among community service agencies or even systemic changes in community service networks. As noted in the *Comprehensive Child Development Program First Annual Report* (CSR, 1991, p. vii):

Conceptually, CCDP embodies the values and ideals of the family support community. Specifically, CCDP does the following:

- Involves the whole family and the whole community in program planning and implementation;
- Establishes a system of networks characterized by peer and staff supports; and

- Serves as a catalyst for connecting various community and public programs and agencies that deliver specific services. [1]

There has been a recent surge of interest in the following:

- Services integration, as indicated by several state-of-the-art reviews of services integration theory and initiatives (for example, see Center for the Future of Children, 1992; Department of Health and Human Services, 1991; General Accounting Office [GAO], 1992; Kahn and Kamerman, 1992; Kusserow, 1991a, 1991b; Melaville and Blank, 1991; Melaville, Blank, and Asayesh, 1993; Morrill, 1993; Ooms and Owen, 1992a, 1992b); and
- The development of a national technical support and clearinghouse organization dedicated to the topic of services integration—the National Center for Services Integration (NCSI).

NCSI defines services integration as follows:

> The process by which a range of educational, health, and social services are delivered in a coordinated way to improve outcomes for individuals and families. Current efforts in services integration strive to overcome the disadvantages of the present fragmented structure of programs and providers, often promulgated by professional specialization.
>
> Effective services integration initiatives emphasize the following:
>
> - Comprehensive services;
> - Early intervention and prevention;
> - Consumer- and family-oriented responses;
> - Family and individual outcomes; and
> - Provider accountability (Bruner, 1993, p. 3).

CCDP shares several of these characteristics, particularly an emphasis on the provision of comprehensive services (through case management and the development of interagency agreements; see Melaville and Blank, 1991), a focus on early intervention, and the goal of fostering individual and family outcomes. However, the goals of CCDP may be more service oriented than system oriented (GAO, 1992), although, according to ethnographers, some

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[1] CCDP projects also are characterized by a focus on (1) optimizing child growth and preparing children for later school experiences, (2) preparing parents as significant change agents in their children's development and in their own development, (3) building on each family's strengths rather than serving only as a remedy for weaknesses, (4) intervening early in the life of a child and family and providing continual support over a sustained period of time, and (5) assisting families in meeting their goals by working with them to establish relevant and viable plans and a roadmap for progressing along these paths (CSR, 1991, pp. vii-viii).

CCDP projects are effecting changes at both the systems and service levels.[2]

Influences of CCDP on Services Integration—Ethnographers' Perspectives

Preliminary analyses of ethnographers' reports led to the discovery that CCDP projects are effecting changes in community service systems, a finding that was subsequently supported by the results of analyses of statements by advisory boards and project directors.

The following is a presentation of the results of these preliminary analyses of ethnographers' reports on the effects of CCDP on community services networks.

The two main types of service networks existing before the implementation of CCDP were classified by ethnographers as being either (1) "not coordinated" or (2) "coordinated." As shown in Exhibit 7-1 following the next page, only 9 (40 percent) of the 21 communities had a coordinated services network in place prior to the implementation of CCDP, while 12 (60 percent) did not.[3] Descriptions of communities with these two types of service networks follow.

In addition, descriptions of changes in community service networks that occurred during the first year of CCDP, and an enumeration of factors associated with facilitating the coordination of the services network are presented below.

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[2] Services integration efforts are categorized as either "system oriented" or "service oriented," depending on their goals. System-oriented efforts have ambitious goals, such as to eliminate the fragmentation of human services by looking for ways to create a new system that would deliver services more comprehensively. These efforts seek (1) to change the way agencies plan and fund programs and (2) to eliminate conflicting eligibility and data collection and reporting requirements of programs serving similar clients. Service-oriented efforts are less ambitious, but their goals can be as difficult to attain as system-oriented goals. Service-oriented efforts attempt to link clients to existing services and unite various service providers without altering the way program officials budget and fund programs, service agencies' responsibilities, or agencies' organizational structure. Service-oriented efforts encourage agencies and providers to share information and collocate many services at one center (GAO, 1992, pp. 2-3).

[3] Interestingly, rural communities were more likely than urban communities to have had a coordinated service network prior to the implementation of CCDP (60 percent versus 37 percent, respectively). It may be that coordination among service agencies is easier to implement in rural areas. In general, rural areas have a small population and fewer service agencies. The service agencies that operate most likely find it necessary to collaborate. It is also likely that urban areas, with their large low-income populations and myriads of agencies providing social services, have a more difficult time attaining service coordination. This report is not the appropriate forum for presenting a comprehensive review of the literature on differences in the nature of service networks in rural and urban areas. In the final report, complete analysis will be provided of differences in service networks in CCDP rural and urban areas in relation to factors identified by a comprehensive review of the literature.

Communities Without a Coordinated Service Network Prior to Implementation of CCDP

Among communities that reported not having a coordinated service network prior to the start of a CCDP project, relationships between agencies serving low-income families generally were regarded as ad hoc and informal in nature. The following example presents some of the barriers faced by communities' efforts to integrate services at an urban CCDP project (Project H Ethnographer Report):

> The key agencies that are currently involved in delivering services to project participants were listed in a previous report. Of those listed, 90 percent of them have a history of serving low-income families. From the outset the participating agencies have established histories of tackling the problems facing this particular population. However, in the past these agencies have operated as separate entities with separate functions that overlap (e.g., counseling, social services, mental health, etc.). Given such isolation, agencies have never come together to build a network of services that could serve families as whole units. Rather, clients have had to seek different services available to them throughout the city, and this has meant extensive travel, time, and commitment. The disjointed nature of social programs in [the city], together with the large volume of people in need of such services often meant that individuals feel as though they are one more number in the welfare system, one more paper to shuffle across some bureaucrat's desk.

While this low-income community had access to a number of categorical service agencies, the efforts to coordinate services for individual families were blocked by territoriality and a lack of leadership and vision. For the most part, community agencies historically have worked independently of one another, although a commitment to work cooperatively and share information on the part of some agencies has increased in recent years.

In some communities, a lack of coordination was reflected in the fragmentation of services and conflicts between public and private agencies. Existing informal service networks often fell short in their efforts (1) to enhance the dissemination of information about services available in the community and (2) to improve accessibility to those services. In communities where service networks were nonexistent or not well developed, CCDP projects faced barriers to providing a system of integrated services. For example, an advisory board member from Project D reacted to the ethnographer's question, "To what extent is there collaboration and cooperation between your organization and other agencies and is it as extensive as it should be?" as follows:

> How can there be collaboration and cooperation between [this agency] and other agencies when there isn't good cooperation and collaboration within [this agency]? We have upper management

Exhibit 7-1

Types of Service Networks

CCDP Project	Coordinated Service Network Prior to Implementation of CCDP	No Coordinated Service Network Prior to Implementation of CCDP
A*	✓	
B		✓
C		✓
D	✓	
E	✓	
G		✓
H		✓
I	✓	
J	✓	
K		✓
L		✓
M		✓
N		✓
P	✓	
Q		✓
R*	✓	
S*		✓
U	✓	
V		✓
W*		✓
X*	✓	
Total (21 projects)	9	12

* These projects are rural.

> people who say, "This is what we'd like to see done." Then we have the workers at the lower level who actually do the things, make the connections, and do what needs to be done. But in between these two [groups of] people are the bureaucrats who can make things very unclear, or make things difficult for whoever is trying to do something. Their job seems to be to put up hurdles and roadblocks to what people are trying to do. I guess I see myself as someone who points this out to people. What we can gather and learn from this project is how to cooperate and collaborate effectively.

Ethnographers found that community leaders were aware of the impact of turf issues on their communities' ability to develop a coordinated service network. For example, a community leader in Project L's area told the ethnographer, "The approach to service—public or private—will determine the success in networking affiliation."

The community leader thought that Project L should approach providers as in need of their assistance rather than impose a sense of authority on the community.

Jealousy, competition, and battles over clients or funding seemed to be the norm in some communities. Interestingly, turf issues tended to be a problem for some projects at the service level but not at the administrative level. For example, there often were battles between CCDP case managers and State social and human services personnel over attempts to obtain housing, rental assistance, or food stamps for CCDP families. Turf issues also involved funding priorities and boundaries set by the agencies awarding the funds. For example, a member of Project D's advisory board commented as follows:

> On a negative level, the inertia of current systems may affect its operation. It's hard to get bureaucrats and bureaucracies to change. Funding is another big part; there's never enough funding to accomplish what you want to or need to. It's a terrific goal to want to make these changes, but how much can you actually change things?

A community leader from Project S specifically referred to "agency-turf protection" as a barrier to developing what he considered "a viable cooperative case management system." This community leader held the view that money, accountability, and services coordination rarely extend beyond the confines of a single institution.

Social service organizations are affected by, and therefore must be attentive to, political climate at the community, State, and Federal levels. For example, agencies attempting to develop a comprehensive, integrated, collaborative project must maintain a certain level of visibility and credibility within local political circles. Examples of political factors that inhibit relationships between agencies include debates about funding by the city council and county commissioners. Unfortunately, community service organizations are sometimes at the mercy of county commissioners who may not be willing or able to expend political capital in order to improve or increase resources for low-income families in their area. As sources of funding for service agencies dwindle, agencies must take a more active role in political discussions about how to best reconfigure community service networks.

Communities With a Coordinated Service Network Prior to Implementation of CCDP

In nine communities there was some level of coordination among service agencies prior to the establishment of a CCDP project (see Exhibit 7-1). Some of the methods used by agencies in these communities to facilitate cooperation and communication among both public and private agencies involved the creation of various types of support groups among professionals with shared goals. The following example was provided by the ethnographer for Project E:

> Administrators working in the employment field have had their own personnel group that has been meeting several times a year for the past 8 years and include representatives from about 20 major public and private employers in the area. Furthermore, while there is no formal organization of mental health agencies in this community, there is an interagency team of State-supported mental health organizations that meets twice a month.

Following is a description of an urban community with a coordinated service network and the factors that contributed to its effectiveness and longevity:

> Over the past 20 years, the relationships among social service agencies serving low-income clients in [the county] have changed. Several changes were clearly in place long before Project U began its planning process. In fact, Project U was shaped by those changes. What were they? First, there was a strong sense of regional identity among the service providers. Second, there were many more agencies in place, often with overlapping specializations and service areas. Third, the agencies were involved in a number of joint projects in which they worked together to serve the same clients. Fourth, they often acted collectively and cooperatively to represent the needs of their clients, communities, and regions to other levels of Government. Furthermore, the agencies watched out for one another; "turf wars" were avoided by tact, discussion, and working together to develop and divide the roles in new joint projects.

Obviously, the service providers in this community placed a high value on the power of cooperation and the development of collective resources. Even experienced providers at Project U were learning the value of cooperation and collaboration, as demonstrated by the following example:

> The...county providers recognize that they are working in an unusual situation. They value the cooperative atmosphere highly; several have turned down promotions to larger areas to continue working in a region where social service agencies work together; and all cite the cooperation as an important "fringe benefit" of service in the region. They actively work to teach the cooperative, informal, flexible style to new providers. One provider with many years of experience in other areas commented, "They were very patient with me, and they are still teaching me how to behave down here." Several "oldtimers" mentioned that it generally takes about 2 years for "newcomers" to relax and discover that the atmosphere is real and to learn that there are behavioral norms operating which are different from those which permeate the social service network in other places.

Finally, a provider at Project U, who has worked in several communities over the last 20 years, commented on why a cooperative atmosphere among local community agencies was possible:

> I think it happens in a few places because a few people see the possibility and build on it. They create networks, those networks are rewarded, and gradually the atmosphere changes from distrust to trust.

Changes in Coordination/Interaction Among CCDP-Involved Agencies

This section presents selected ethnographers' descriptions of changes in community service networks that occurred in the first year following the inception of CCDP. These descriptions suggest that, in some communities, CCDP projects began to facilitate services integration at both the service and systems levels within the first year of serving families.

Ethnographers reported that one of the most important changes in the relationships between service agencies since the implementation of CCDP has been that major county and State agency directors are working together—along with employment and training, human service, health, and various private nonprofit providers—to better serve low-income families. CCDP-sponsored meetings have brought people together in ways that suggest a new model of how to implement and operate comprehensive, integrated, and collaborative family services projects. Coordinated efforts have focused on specific populations and needs, such as the homeless, emergency funds, food, clothing, and energy assistance. Changes in service networks that have occurred since the inception of CCDP include development of new linkages and strengthening of other linkages, increased interagency awareness and understanding, and more frequent interagency case management staffings.

Of the 12 projects reporting information, 10 (83 percent) have experienced some form of change among the service agencies since the inception of

CCDP (see Exhibit 7-2 following this page).[4] Of that 48 percent, most (90 percent) of the projects were urban. As noted earlier, rural areas were more likely to have an existing coordinated service network. The inception of CCDP has acted as a catalyst in urban areas for changing relationships among service agencies.

Staff from different agencies often work together on a daily basis. For example, in Project R's community:

> Coordination among agencies is occurring at both the staff and administrative levels. CCDP staff have the daily contact with the staff of other agencies and, as one county coordinator stated, "this empowers the staff to be the primary initiator for interagency work." Coordination mechanisms have primarily been meetings either in person or by telephone between line staff.

The following statement of a Project D advisory board member further illustrates changes in service provider operations and attitudes:

> We need more public and private collaboration. A lot of people talk about public-private collaboration, but it's just a lot of rhetoric. We need leadership—the right people who can make it happen and make it last long term. I'm impressed with Project D. They have the right people at the table. Collaboration is very scary though. It involves risk taking. Collaboration must happen for this project to work.

This example suggests that, by participating in interagency meetings in formalized settings, each staff person obtains an intimate knowledge of the services available from other agencies. This additional knowledge facilitates CCDP staff's efforts to identify and access services needed by CCDP family members.

CCDP projects have taken the initiative to try and improve the quality of the local services network. As a result, CCDP and non-CCDP staff now are able to access a wider range of inservice training activities. As explained by the ethnographer for Project K:

> Project K's Provider Subcommittee meetings, which occur every 3 to 4 months, are a major mechanism through which Project K is attempting to establish interagency communication. In addition, representatives from local service providers have been invited to provide training at Project K, and Project K staff have visited and spoken at several local providers organizations....Project K also had planned to foster interagency ties by providing inservice training to local service providers....whose staff also have visited and spoken at

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[4] Five communities had a coordinated services network prior to implementation of CCDP, and five did not have a coordinated services network prior to implementation of CCDP.

Exhibit 7-2

Effect of CCDP on Service Networks

CCDP Project	Service Networks That Have Experienced Changes Among Service Agencies Since Inception of CCDP	Service Networks That Have Experienced No Changes Among Service Agencies Since Inception of CCDP[1]
A*		✓
B		N/A
C		N/A
D	✓	
E	✓	
G		N/A
H	✓	
I	✓	
J		N/A
K	✓	
L	✓	
M		N/A
N	✓	
P		N/A
Q		N/A
R*	✓	
S*		N/A
U	✓	
V	✓	
W*		N/A
X*		✓
Total (21 projects)	10	2

* These projects are rural.

[1] N/A indicated that the ethnographer did not respond to this question.

several local provider organizations. In addition, Project K provides inservice training to local service providers.

CCDP's philosophy and goals also facilitate services integration by encouraging networking among CCDP staff. In addition, CCDP attempts to employ staff who understand and will comply with the CCDP philosophy of collaboration. Most CCDP staff realize that the goal of services integration and coordination is an essential component of efforts to provide families with comprehensive and integrated services via the case management process.

In communities that had a system of integrated services in place prior to the inception of CCDP, CCDP staff have worked to improve and expand the existing services networks by providing new services, strengthening the existing pool of services, or facilitating communication and cooperation among community, State, and Federal agencies. Because many CCDP projects are located within established grantee agencies that have a history of initiating collaborative programs sponsored by various privately and publicly sponsored agencies, the grantees generally encourage the CCDP projects to pursue these activities and support the CCDP projects in their efforts to foster service integration. In this case the relationship between the CCDP projects and their grantee agencies is mutually beneficial.

For those CCDP communities that had an existing cooperative social services network, CCDP projects have reinforced and enhanced the value of working collectively. The advent of CCDP supports the existing focus on providing comprehensive case management for low-income families, and CCDP serves as a vehicle for implementing services other agencies were unable to provide.

In several projects the information exchange among the members of the community services network has increased due to the creation of CCDP advisory boards. The CCDP advisory board includes community leaders who share their expertise with CCDP projects and serve as advocates for CCDP among members of the organizations or communities which they represent. Each advisory board includes CCDP families, business representatives, and community service leaders. At advisory board meetings, members from the various agencies work together to develop a system of coordinated management of families for which they share responsibility. In this context there is potential for CCDP to continue to enhance and focus interagency cooperation. This was noted in the following example, provided by Project E's ethnographer:

> ...this new approach [collaboration] has been highlighted in larger, less ephemeral groups. Such is the case in Project E's own advisory council, whose members represent a microcosm of the service world that a comprehensive, collaborative delivery system might need to draw on; among council members are managers of organizations involved in health, early childhood, employment, mental health, child

> care; the business community; the political system; and the school board and school system. The topic of interagency cooperation comes up often in the course of discussions within this group, and at one recent meeting Project E's director brought the issue into focus by describing one of the program's "successes" on this score. A Project E mother had been in crises and in need of a month-long substance abuse treatment program. Project E staff worked with mental health as well as several child care and transportation organizations to quickly orchestrate arrangements for this woman and her two children. During the discussion that followed this account, a council member who directs one of the agencies that had been involved in helping this family praised Project E's model of service delivery. Discussions of this sort cannot help but stimulate and raise consciousness about the importance and possibility of making collaboration work.

For most CCDP projects, collaborative efforts between agencies in the service network increased between the inception of CCDP and April 1991 (the period covered by the ethnographers' reports cited in this section). Agencies agreed to provide specific services for CCDP families at no extra charge or at a nominal charge to CCDP. Some interagency agreements went so far as to specify that CCDP families be given priority access to services and to suggest what types of information would be exchanged.

Ethnographers found that coordination and interaction among service agencies usually starts at the administrative level, as interagency agreements are drafted by the CCDP project director and other agency directors. The interagency agreement then is implemented by line staff, usually case managers or home visitors. The following example provided by Project B's ethnographer illustrates this process and some of the problems faced when attempts are made to coordinate the services received by families:

> At the present time much of the interagency coordination interaction is at the administrative level. This is primarily due to the need to develop interagency agreements in meeting the project's expressed goals. As interagency agreements are implemented, much of the contact is then shifted to the case managers in order to pair the family needs with the services provided by the agency. This brokering of services is a major activity of the case managers. A major difference in the project...is that the case managers do not just refer their clients to services but broker the services and make certain that the pairing of persons and program is met. This is, of course, often an interesting and frustrating task, as pairing a family with a new service may have a ripple effect on the other services the family is receiving and quite often schedule juggling takes place in order to fit the new service into the schedule. This problem is exacerbated by the lack of public communication and transportation services.

Factors Facilitating the Coordination of the Services Network

The service networks that have developed in CCDP project communities were built through previous connections. CCDP project directors and staff typically have an extensive background in the social services arena and have numerous contacts on whom they can call. Personal relationships and strong negotiation skills seem to set the tone for cooperative ventures.

Ethnographers identified four main factors associated with facilitating the coordination of the services network: (1) case managers, (2) an active and committed advisory board, (3) formal interagency agreements, and (4) a supportive grantee agency. These factors operate at different levels of the service network (e.g., the case manager at the line staff level, the advisory board at the administrative level, and interagency agreements at both the service and administrative levels of the service network). Each of these factors is discussed below.

Case managers.—Case managers act as advocates for CCDP family members from the establishment of a goal to its attainment. The case manager often can make numerous friends and allies in the service community simply by assisting all the other agencies in securing services for one particular family or family member. Project R developed an interesting training program designed to facilitate collaboration among service providers. This program was explained by the ethnographer as follows:

> Service linkages central to the CCDP concept require more extensive and more frequent interaction with other agencies. New CCDP staff visit with other agencies as part of their job orientation. This process serves to increase staff knowledge about other agencies and allows other agencies the opportunity to meet CCDP staff. In [the county], one such visit was a catalyst to mend an unknown negative relationship between the CCDP's grantee agency and the public health department. Prior to the case manager's courtesy visit, the public health nurse stated she had little respect for the grantee agency based on negative interactions with the previous grantee county coordinator. The new grantee county coordinator, the public nurse, and the CCDP staff met and resolved many of their feelings, resolved other concerns regarding CCDP's role with family health issues, discussed ways to coordinate and collaborate information, and made an agreement for quarterly family staff meetings.

Advisory board.—Advisory boards facilitate coordination by sharing information with other agencies and by locating resources in the community or at the State and Federal levels. Members of CCDP advisory boards are invited to participate in activities sponsored by other agencies, thereby increasing mutual awareness and understanding among the staff of CCDP and other related programs.

CCDP advisory boards consist of CCDP families, business representatives, community leaders, and community service providers. The main objectives of advisory boards are to elicit community support for CCDP, foster the development of interagency agreements, provide technical assistance and resources as needed, and provide leadership for CCDP projects. As noted earlier, a community advisory board committed to the philosophy and goals of CCDP facilitates services integration in the community. The inclusion of community leaders on the advisory board has influenced the development of community-based systems of services integration. Advisory board members, particularly those at the State level, play a key role in services integration by providing information about grants and other sources of funding for which CCDP could apply in collaboration with other agencies. The advisory board is, in many cases, the primary vehicle for ensuring that the issue of services integration remains a priority in the community.

An example of how one advisory board (Project I) facilitated services integration is as follows:

> Many of the advisory council members were part of the original planning committee to develop the project proposal. Some of these members had input by recommendation and review into the selection of personnel who occupied key positions within the project. When formal or informal agreements existed with the agency, the advisory council member usually played a key role in the development of the document. When a problem arises within the parameters of the agreement, they [the advisory council members] can usually be counted on to assist with problem resolution. Child care funding is one such problem. Potentially all primary caregivers (CCDP family members) who receive AFDC and meet [the] other [agency's] criteria are eligible to receive payments for child care from [the other agency]. Only one Project I parent actually had received money from [the other agency]. Also, to date the money had not found its way to Project I, although Project I was providing the child care. A meeting was held at the Department of Social Services [DSS] with the DSS administrator, Project I director, the ethnographer, and other staff. The DSS administrator suggested a chart to be developed by Project I showing its current collection from DSS for child care and measuring the progress during the next year. During this meeting Project I staff and DSS staff informally covered areas identified in the interagency agreement. They collaborated on problems involving their mutual clientele. They shared resources, i.e., the assessment center opened to Project I as an entry point, along with potential reimbursement for child care and case managers to assist [the other agency's] staff in followup activities. It was apparent throughout the meeting that the DSS administrator, who is also an advisory council member was making it known to his subordinates that he wanted the things discussed in this meeting to be carried out, hence the chart for monitoring the progress he suggested. There are numerous examples like this where problems are brought to the advisory

> council, and members of the council use their positional and personal authority to facilitate resolution.

The parents who are on CCDP advisory boards play an important role in cooperation among service agencies. CCDP parents also can use the advisory board as a means of affecting change in "the system." An example of parents' roles on advisory boards was noted in a Project S ethnographer report as follows:

> Another factor that has influenced cooperation between the agencies and program families has been the parents who serve on the advisory board. This has given the agency representatives who are on the advisory board an opportunity to see first hand the impact being made on program families. It also has been good for the parents to meet these representatives in an informal setting and see them in a different light.

Formal interagency agreements.—Interagency agreements act as facilitators by providing the means of acquiring services for CCDP families. Projects have developed written interagency contracts or agreements that delineate roles and responsibilities, activities, and timeframes for each agency. The agreements aid in establishing common definitions, including the definition of the population to be served, and lead to a better understanding of what agencies can expect from one another.

Supportive Grantee Agencies.—CCDP grantee agencies that held a major leadership position in the community often were able to facilitate the process of developing and implementing interagency agreements. Also, community agencies generally were not intimidated by CCDP projects established within a recognized community organization with its own funding streams, because these CCDP projects were not viewed as competitors for funds that other service agencies relied upon.

Influences of CCDP on Services Integration—Project Directors' Perspectives

Information provided by CCDP project directors indicated many local efforts to make CCDP project service delivery comprehensive in nature, and detailed many changes in service delivery systems that were communitywide in scope. Efforts at providing comprehensive service delivery facilitated greater levels of cooperation between agencies as well as the development and utilization of referral systems.

CCDP Projects' Efforts To Coordinate, Deliver, or Make Available a Comprehensive System of Services

Within this category two major issues were discerned: (1) facilitation of cooperation between agencies and (2) development and utilization of referral systems. Each issue is discussed below.

Facilitation of cooperation between agencies.—Many projects described how they maintained amiable relationships with other agencies by avoiding duplication of services and utilizing resources already offered in the community. The director of Project H made the following comments:

> The onsite CCDP family counselor has developed strong collaborative relationships with other...community providers, including mental health resources, social service agencies, [and] health and drug programs. This has resulted in improved access, service provision, and continuity of care for CCDP families. Additionally, resources are being provided in a complementary fashion, and duplication of services is avoided.

As a result of following this integrative approach, Project G was able to help families access needed services, help other agencies identify eligible individuals in need of their services, and support and monitor the ongoing services to ensure compliance and reduce access barriers.

The project director at Project E made the following statement regarding CCDP staff members' leadership role in fostering interagency collaboration and in searching for funding that would benefit all community service organizations:

> CCDP [project] staff have spearheaded and are involved in many initiatives. For example, the director and other staff members have provided leadership in the [local] interagency committee, a planning group with wide community representation. Some of its initiatives include an annual Family Friendly Business Award (given to three area businesses), an interagency team which addresses the issues of teen parents, and a [special] group that organizes a week of activities that celebrates children and families.
>
> Through our efforts and example, the number of interagency case management activities has increased in the community. We also make team home visits with staff members from other community agencies. And our staff co-leads parent education groups with personnel from community agencies such as the health department, mental health agency, schools, and the child protection agency.
>
> Our staff have collaborated on several grant proposals with other community agencies and have played an active role in the writing of grants. Our grant writing has resulted in the community receiving a

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New American Schools grant, an Even Start grant, community development funds, and funds to buy a building for a family resource center in one town.

Development and utilization of referral systems.—Project directors felt that the system through which families are referred to CCDP from other community agencies was considered very valuable. The following example describes why the directors perceive that families and the community are best served by this process:

> Project W receives many referrals....Because of [its] implementation strategies as well as the use of the team approach that is inclusive of other agencies, the program has gained a tremendous amount of respect among service providers in the community. The program always is making referrals to Project W and feel that the staff members of Project W work well with participants.
>
> Project G also receives direct referrals of families from other agencies. However, this project noted, "...agencies are disappointed when they realize that Project G cannot accept more program families. The agencies have seen the positive outcomes for other families."

Changes in Service Delivery at the Community Level

Project directors commented about changes CCDP projects have made in service delivery in the community. Within this broad category, three major issues were discussed: (1) CCDP's role in the development of collaborative relationships with other community agencies, (2) CCDP projects as a model for other agencies, and (3) CCDP projects' role in changing community attitudes and practices vis-a-vis low-income families. Project directors noted that family member and staff involvement in the community and projects' joint ventures with other community agencies had positive impacts and that their projects served as models for other programs or for Government planning. Project directors are also of the belief that agency staffs' and businesspersons' attitudes and practices changed upon becoming involved in CCDP advisory boards. Finally, project directors noted that the general public's awareness of poverty and self-sufficiency issues increased as a result of CCDP's efforts. Each of these themes is explored and illustrated below.

CCDP's role in the development of collaborative relationships with other community agencies.—Through interagency agreements with other community agencies, CCDP projects have increased the availability of services in their community. For example, at Project U, a local businessperson noted:

> I have observed young mothers speaking gratefully about important help they have received from agencies they never knew existed prior

> to Project U's involvement. As these services have their impact, the parents' attention moves from worrying about their child's health and development to attending to their own abilities to provide for a family.

Another example of a successful interagency agreement provided by the project director from Project W is as follows:

> With the [State] Department of Social Insurance we have entered into an agreement for all project recipients eligible for Job Opportunities and Basic Skills (JOBS). Under the agreement, Project W would provide case management services and the [department] would provide all the supportive services required by JOBS (e.g., child care and transportation).

Day care services have been improved and/or expanded as a result of interagency cooperation. For example, Project U's State utilized a Child Care Block Grant to fund day care services for the members of a local Native American tribe. However, Project U noted the following:

> There was difficulty with startup, and then Region X administrators asked Project U to assist the tribe in getting the center off the ground. The center was run jointly for 1 year. The tribe now is getting ready to take over this center as planned, expand the Head Start program, and open a second child care center.

Furthermore, in addition to facilitating additional child care slots in the community, this CCDP project "also generally enhanced the level of child care expertise on the reservation."

Other examples of how CCDP projects facilitated the availability and accessibility to child care include the following:

- Project W will be working with several community agencies and a child care referral service to develop Family Day Care homes in the community where the participants live.
- Project S works collaboratively with Head Start on transportation and child care. Head Start serves some Project S children in part-day programs. Head Start social service staff serve as Project S family advocates. Project S trains and supervises the staff on comprehensive case management methods, thus benefiting Head Start.
- Project S has greatly influenced the accessibility and affordability of child care in rural areas of the State. Previously there was no infant/toddler care in some communities and only very limited quality preschool care. Project S has provided training on quality care for child care providers and parents.

At Project A, the project director reported:

> [Another] impact is that the project child specialist has been actively involved in organizing training for child care providers to improve the quality of child care services. In addition, she provides training directly to over 20 child care providers per quarter.

During the CCDP project startup phase, community agencies that had not been linked previously began working together to provide services for non-CCDP families as well as for project families. For example:

> At Project U, the children and families commission has designed its initiatives around community-based family support principles and has funded two initiatives that were influenced by Project S and involve major community service expansion: a family resource center provides services to all tribal members, such as food and clothing, parenting, youth employment, drug and alcohol counseling, and an expansion of Project S that provides services to all pregnant or new mothers in the community.

CCDP projects as models for other agencies.—Several directors described how other institutions (including Government agencies) have developed new programs or modified existing programs according to CCDP's example, including the following:

> Project S is one of only two CCDP projects in the Nation that has established its delivery sites in public schools. The program's five family resource centers (FRC's) provide comprehensive integrated services and serve as model sites for the school systems which enroll many thousands of children. The school systems have applied to the State to establish more FRC's in their counties. Project S held an FRC conference for 45 State school systems on school-linked services. The CCDP FRC's were observed as model sites for reaching all families and preparing children to enter school ready to learn.

Furthermore, Project U's director reported:

> The [commission] has designed its initiatives around community-based family support principles and had funded two initiatives that were influenced by Project U and involve major community service expansion: This year (1993) it funded the...FRC, providing services to all tribal members, such as food and clothing, parenting, youth employment, [and] drug and alcohol counseling.

The project director of Project N reported that the county plans to elaborate on the concept of CCDP's family support programs as follows:

> Community leaders have talked about Project N as a model for family support programs in [the] county. In open meetings of

> community groups, agencies, and local politicians, Project N often is called upon to describe the mission and services of CCDP. The county is submitting a proposal to the State to develop new FRC's based on the CCDP model.

Finally, the director of Project A commented on CCDP's far-reaching effects at both the regional and State levels:

> The [regional office] of Family Support has implemented a number of changes in its system as a function of exposure to the CCDP project. These have included changes in its policies and procedures related to economic self-sufficiency and case management, and the conduct of focus groups for Aid to Families with Dependent Children (AFDC) families.
>
> The mental health program for children and adolescents at the State level has adopted and adapted some of Project A's policies and procedures related to wraparound services and case management.

Communities' changing attitudes.—Some CCDP projects influenced the way communities viewed and delivered services. As the director of Project B explained:

> CCDP projects are in a unique position locally and nationally to lead the way toward the identification of specific needs/changes and to bring with it the full support of an enlightened community.

CCDP projects solicited community members for advisory board positions as a means of introduction and education for them and a promotion for the project, such as the following:

> Project S takes the approach of involving business leaders as partners to enhance the image and effectiveness of the program. Thus, the business council has grown from 10 to 60 members in 3 years. A change in the attitudes of the board members as a result of their involvement is reflected in their increased awareness of welfare disincentives and the need for multiyear, intensive programs to reduce welfare participation.

In addition, directors reported that their projects had affected the communities' views of and attention to issues relating to families' economic and social self-sufficiency. For example:

> Project S provides the case management intake for the Section 8 Housing Self-Sufficiency Program. Over 20 percent of the CCDP project's parents are now off of long waiting lists and into improved housing. Also, the Project S Business Council has assisted some families owning or planning to own their own homes.

Project W mobilized community resources in its effort to address self-sufficiency issues as follows:

> Local organizations that provide emergency assistance to families in [the county] have redirected their efforts to provide assistance to families working toward self-sufficiency. As a result of this change, organizations now only provide funds to individuals who are working toward self-sufficiency. This change in direction has resulted in the following impacts:
>
> - These organizations will provide funds to individuals only if they are working toward self-sufficiency.
> - The organizations have been able to assist with nonemergency funds for such items as tuition assistance, clothing, school supplies, and books.
> - Volunteers in these and other organizations have provided food and gifts at holidays.

Influences of CCDP on Services Integration—Advisory Boards' Perspectives

The content analysis of the advisory board statements revealed a more homogeneous set of issues regarding the influence of CCDP on services integration as compared to the ethnographers' reports and the project directors' statements. Three general issues worthy of exploring at a later date in more detail because they are consistent with the themes revealed by analyses of ethnographers' reports and project directors' statements could be discerned, however. These themes were as follows: (1) services integration at the systems level was fostered by the implementation of CCDP and, in some cases, this occurred for the first time in the community; (2) advisory Boards were actively involved in ensuring that the gains made in services integration in the community continued for the long term; and (3) services integration fostered by the CCDP benefitted both CCDP and non-CCDP families. Each of these themes is discussed below.

Services Integration at the Systems Level

Whereas a majority of the CCDP advisory boards mentioned the establishment of, or improvement in, relationships among community agencies and organizations all galvanized around the common cause of helping low-income families, several advisory boards indicated that their CCDP projects had facilitated a deeper, systemic change in the community services network. This change came at a moment when the existing services network structure could no longer adapt to the changing economic and social circumstances in the community. For example, the advisory board for Project D wrote:

> Our community, unlike any other in the Nation, has led the country in economic, social, and urban development over the past 15 years. In fact, in that short amount of time [the] metropolitan [area] has become one of the 10 largest metro regions in the country. Amid the boom, however, [there] has not been a parallel growth in the social service delivery systems necessary to support and advance a population of over 2 million persons. Further, our public spending for health and human services has not matched the population growth, creating a dwindling supply of services in a highly competitive philanthropic climate with no additional monies available.
>
> The timing for introducing CCDP into [the] county could not have been more advantageous for making a significant contribution to our community's evolution. Over the past 3 years, a number of significant programs or reports have emerged from [the project] that will not only have considerable systemic impact for today, but will also create a legacy for shaping the [local] social service system in years to come.

The goal of integrating services across agencies and programs has been achieved for the first time in some communities as the result of implementation of the CCDP project. For example, according to the advisory board members from Project L:

> This was the first program in the community to have interagency agreements and work in a collaborative effort to eliminate duplication of services. The agreements have influenced the coordination and integration of services within the community. According to one service provider, the interagency agreements assist in building a relationship which allows for staff to meet each other and establish good rapport and working relationships. In an area where "turfdom" has been a tradition, this has been quite an accomplishment. Project L has over 30 interagency agreements.

Below, Project L's advisory board gives specific examples of the consequences of the CCDP-initiated interagency agreements and notes the central role of CCDP in this effort:

> Project L has been instrumental in fostering collaboration for various projects, grant proposals, training sessions and the formation of a number of consortiums. One example is the receiving of a small grant from [a philanthropic foundation] to assist the women in the southern, very rural area of the project in organizing a women's conference, which they did completely on their own. The conference was very successful, but beyond that, these women developed a great deal of self-esteem and confidence and have since formed a women's club for the community that continues to address various topics of interest to the group. Most recently, a joint proposal was developed

> with the [local] school district, which would enable the school district to work with the community in nontraditional ways. Joint projects with a number of agencies have brought instruction in health, nutrition, parenting, substance abuse, and other topics to a community that would have not been done if it wasn't for the existence of Project L.

Advisory board members from different projects noted that the role of CCDP goes well beyond the traditional social work model of simply providing services to low-income families and beyond efforts to simply link agencies through formal or informal agreements by facilitating the development of an integrated service network that addresses individual families' needs and goals. For example, according to a member of Project X's advisory board:

> In my position...I am responsible for all professional services and coordination of community resources for individuals and families throughout the entire lifecycle. The project has been able to remain flexible enough to truly respond to individual/family needs rather than be just a dispenser of services. Not only are the services comprehensive, coordinated, and compatible, but the attitude of the staff and those involved in the project has fostered full integration at all levels and in all areas.

Furthermore, the advisory board of Project H wrote the following:

> Because of the interagency partnerships the project includes, agencies that heretofore have not had occasion to work together in such close proximity now know one another's organizational resources more indepth and can utilize this knowledge in programs beyond Project H.

The amount of Government dollars earmarked for social services is shrinking. Therefore, in addition to fostering interagency integration and coordination among social services agencies, CCDP projects also must make a concerted effort to include private and business organizations in the local services network. This provides an additional source of leadership and funding to bear on the problems faced by low-income families. For example, advisory board members at a rural CCDP project, Project A, agreed that CCDP has made two critical contributions to the community, one of which is to bring together

> ...policymakers and providers from the public, private, and business sectors to discuss community issues bearing on the success of low-income families who are trying hard to succeed in making their lives better through effective parenting and economic self-sufficiency. The result has been an improved atmosphere for interagency cooperation, more mutual understanding and trust, and better working relationships.

Advisory Board Plans To Foster Services Integration in the Future

The advisory board members of Project I noted that they are implementing a long-term plan (1) to protect the gains made toward changing the community service system and (2) to set up mechanisms to allow for further refinements in the system in the future. Project I's advisory board felt that this strategic planning would significantly impact the community by bringing together

> ...the goals and objectives for governance, administration, and service delivery. Part of this plan may well include a systematic method of collecting client consumers' attitudes toward, and opinions about, the services provided.

Other CCDP advisory boards also are planning for the future needs of low-income families. Advisory board members at Project D, for example, have volunteered their time to the following:

- Increasing the amount of child care spaces through a lobbying effort with the municipal government;
- Enhancing staff skills in prenatal care delivery while increasing client access to services; and
- Developing a network of business relationships that will result in employment development opportunities, including increased business representation on the local advisory board.

Services Integration Benefits Both CCDP and Non-CCDP Families

The Project G advisory board provided an example of CCDP facilitating public and private ventures that benefit both CCDP and non-CCDP low-income families. The following statement also illustrates the creative use of different types of interagency agreements and the mutual benefits of interagency agreements for CCDP projects and cooperating agencies:

> A third view of success comes from the progress made in the area of interagency collaboration. By its very nature, Project G has developed interagency agreements. Those formal written agreements number over 60. Some of these agreements are simply methods of utilizing existing services, but many represent new levels of services through this collaboration. For example, the formal relationship built with the Private Industry Council (PIC) has helped both agencies. PIC was having trouble contacting families who needed highly skilled employment training while Project G had the families who desired this service. Both are now experiencing success. We now hear others talk of developing interagency agreements. Additionally, Project G has acted to support the goals of other

agencies in informal ways. In fact, a representative from the State's welfare system has commented positively about Project G and how the two agencies have worked together in the area of "family preservation." Another example of this collaboration exists with the recognition of the number of Project G staff who are on the boards of other agencies or who are being asked to share their expertise. Staff are on the Literacy Council, the Children's Coordinating Council, training committees, and numerous other groups.

Influences of CCDP on Families

CCDP parents are the main beneficiaries of CCDP's philosophy and management efforts which are focused on affecting services integration. In this section the influence of CCDP on families as the main beneficiaries of services integration fostered by CCDP is discussed from two convergent perspectives—(1) that of the project directors and (2) that of the advisory boards.

Influences of CCDP on Families—Project Directors' Perspectives

Because of their daily contact with families, project directors observed that strong case management helps families obtain a wide range of services and goods from the community. Project directors emphasized that CCDP projects encouraged interagency cooperation and, therefore, more comprehensive care because they did not waste time or resources by competing with other social service agencies. Finally, project directors believed that the referrals CCDP projects received from other agencies promoted cooperation among agencies and served the families more efficiently.

The following statement made by the project director of Project G sums up the impact that CCDP projects have had on service systems in many communities:

> A frequent response of other community agencies is, "We're glad you're here to help us." This reflects the purpose and mission of CCDP. The CCDP projects were initiated for the purpose of helping families to identify needs, set goals, and access whenever possible existing services to meet those needs....This approach prevents many of the traditional turf issues, and agencies view us as their advocate as well as the family's advocate. As a result, Project G is helping in three ways:
>
> - It helps families access needed services;
>
> - It helps agencies identify eligible individuals in need of their services; and

- It supports and monitors the ongoing services to ensure compliance and reduce access barriers.

As a result, everyone benefits from this comprehensive, case management approach.

Community service agencies, caseworkers, and educators have learned that, in addition to building alliances with other service providers, they must join forces with project families as well. At Project U, the director wrote the following:

> Social service providers have learned to work more in partnership with their clients and value the input they give to shaping their future. They have learned to recognize the strengths of these young families and help them to further develop their strengths....Educators have learned many of the same lessons as the social service providers....They have learned how working in partnership with parents brings out the best in their students. Educators of the parents have learned about the strengths and determination of these young families and how it is possible for them to grow, develop, and mature given the support and understanding they need.

Project directors reported that their projects have assisted families in the areas of housing, tuition payments, child care, transportation, protective services, clothing, food, gifts, automobile loans, and medical treatment. The following examples demonstrate how different projects have offered comprehensive case management to their families:

- Project W has collaborated with a career resource and training center (a Job Training Partnership Act [JTPA] administrator) to use JTPA funds to assist Project W participants with tuition and child care where other funds cannot be located. In addition, the job search assistant works with the on-the-job training (OJT) staff to develop OJT contracts with local businesses and industries that will hire project participants. If the contract is written, the employer could be reimbursed up to 40 percent of salary paid for the employee's first 13 weeks of employment.

- According to the project director at Project S:

  > ...[CCDP] has improved transportation for families to receive health services through advocacy for medicaid transportation and, based on the Project S business council's advocacy, more families have been able to obtain car loans to enable them to pursue employment.

According to project directors, family members have become involved in a variety of community activities. CCDP family members have taken on advisory roles with community programs, performed volunteer work for the project, or found employment in social services. For example, according to one project director:

> At Project H several family members have been doing volunteer work in community service capacities. One family member has become actively involved with a black student services group on the campus of a local college. Another member has become involved with a group working on the impact of lead poisoning on children under [the age of] 6. As a part of this group, she will be attending the National Youth Law Conference.

The Project X project director, reflecting on the experience at her site, noted the following:

> Moms are volunteering at day care centers and preschools that their children attend. They are involved in babysitting bartering, and one [mom] provides child care weekly for a [support] group. Parents are volunteering as in-class school aides, and one volunteered to be a school district census taker....The project has provided opportunities, motivation, and incentives for families to give back to their communities by helping with clubs, church, Head Start, and school activities and by participating in other volunteer activities such as blood drives.

Influences of CCDP on Families—Advisory Boards' Perspectives

CCDP staff have lent their expertise to other community agencies by serving on their advisory boards or even providing direct technical assistance to them. For example, at Project H

> ...a staff member serves on the Parenting Education Task Force of the local community college and education system. This task force is developing a curriculum for parenting education, which will be offered in high schools throughout [the State] as part of the senior high occupational education program.

Without exception, each of the CCDP advisory board statements referenced the positive impact CCDP has had on the lives of family members. It was clear after reviewing the advisory board statements that CCDP advisory board members had a good understanding of the nature of the "CCDP model"; the types of services provided or made available by CCDP projects; and the effects the CCDP projects have had on parents, children, and other family members.

The advisory boards also discussed the advantages that project family members have gained as a result of participation in CCDP. For example, the advisory board of Project G supported its contention that its CCDP project has been "a success" by reporting the following: (1) children born to parents in the project weighed more than children born to similar populations, (2) the birth of premature babies has been virtually eliminated among women participating in CCDP, (3) Caesarean sections have been reduced dramatically, and (4) the number of CCDP parents employed has increased by 100 percent since the project's inception.

Other advisory boards focused on the range of services made available to both CCDP and non-CCDP families. Some of these services were already available; however, in other cases the CCDP project facilitated accessibility to services or created new services. For example, Project B's advisory board highlighted the following services:

- *Child care services.*—Increased day care and child development services are now available [via two new child care centers and one new family day care home].

- *One-stop shopping/Department of Human Services' (DHS') centralization.*—The State DHS has made a commitment to provide an opportunity for residents to obtain needed services in the community, and the CCDP project has made office space available for this purpose.

- *Education.*—A number of participants have utilized education services made available by the project to assist them in obtaining a GED (general equivalency diploma), completing high school, and attending college. Without transportation assistance, child care, financial help, and other assistance, most project participants would not have been able to reach these goals.

- *Parenting skills.*—Due to parenting classes sponsored by the project, parents in the community have been exposed to modern strategies for childrearing via highly qualified and respected staff, videotapes, onsite instructors, curricula, and so forth. Thus, strong interest in and the desire to become better parents has been fostered in participants.

Data illustrating the impact of CCDP on children and adults were provided by Project J's advisory committee, as follows:

- More than 482 children have received services which include prenatal care, immunizations, vision/hearing screenings, referrals for diagnosis and treatment of handicapping conditions, and well-baby checks.

- Forty-eight program adults have been enrolled in high school/GED classes, and 22 have successfully completed these classes.

- Twenty-nine program adults have enrolled in college/vocational courses of study, and 11 have successfully completed their courses.

- Fifty-four families have participated in community-sponsored activities, such as parents-as-teachers training, drug abuse prevention/treatment, English as a second language classes, immigration rights seminars, and family counseling.

Other CCDP advisory boards have commented on the progress made by CCDP families toward economic self-sufficiency, as measured by reductions in entitlements to families. For example, Project W's advisory board noted the following:

> In relation to family progress, we have seen a reduction in entitlements to families as they move from AFDC, Medicaid, food stamps, and public housing. Nearly 15 families in Project W maintain a wage which makes them ineligible for entitlements. In addition, 25 family members are enrolled in an educational or training program which, if completed and employed, would provide a self-sufficient wage for families.

One of the benefits of helping families reduce the number of entitlements needed is that an increase in available resources for other more needy families will result. For example, the advisory board of Project W made the following assertion:

> In the area of health we have decreased expenditures for emergency health care by placing emphasis on preventative health care. Of particular interest, 100 percent of families have received a health screening by a public health nurse and all children born after their family entered Project W have received well-baby checks, and there has been a 50-percent increase in immunizations among the children in Project W. [Furthermore, there was a reduction in the number of pregnancies occurring among Project W families from 13 percent in 1991 to 5 percent in 1992.] Finally, the developmental progress of the children has improved over time. In addition to reducing the number of children who exhibit developmental delays, it appears as if a significant number of children in Project W are testing above their age.

Other CCDP advisory boards have noted the increased level of participation of CCDP family members in the community. Rural communities are in particular need of volunteers because of the scarce resources and long distances among families in rural areas. Fortunately, CCDP families in rural areas are helping fill this need. For example, at Project A, CCDP families have been involved in the development and operation of the local community health clinic. And like all other CCDP projects, CCDP family members serve on the community advisory boards or parent councils of these rural CCDP projects. For example, Project B's advisory board suggested that participation in its parent council and advisory board "serves as a strong mechanism for leadership training."

In one urban project, parents have played a particularly visible role in the operation of CCDP. According to Project C's advisory board:

> The Parent Council, made up of participants, has managed a successful food co-op for 6 months. In the process of arranging a

> linkage agreement with the Tenants' Association of the [local] public housing projects, they have allowed residents of the projects to become members of the cooperative. The Project C participants have taken on the full responsibility of administering and implementing the food cooperative.
>
> [Furthermore], four male participants of Project C have been enrolled in a security/escort project. They escort our staff members to and from their home visits, serving as a visible reminder that Project C cares about its people.

Finally, a statement from the advisory board of Project L, which is located in the southwestern United States, illustrates how participation in a CCDP project has led to some basic changes in the thinking of some low-income families with regard to state-of-the-art knowledge about child development. The board's statement is as follows:

> With the area's population mostly traditional Hispanic families, many of Project L's families never considered the concept of day care. To relinquish your child to other than a family member was unheard of. Many families now realize the importance of the socialization of their children not to mention the practical aspects of being free to work or go to school. We consider the ability of CCDP projects to effect changes in parents' basic attitudes about childrearing to be one of the most important findings of our analysis of CCDP advisory board statements.

CCDP advisory boards have played a critical role in the implementation and continued operation of CCDP projects, and many of the advisory boards are taking a proactive role in planning for the future of CCDP.

Influences of CCDP on Grantee Agencies

All CCDP projects operate under the auspices of a larger, overarching grantee agency. These agencies differ in size, type (e.g., hospital based, university based, school district, and community action), and experience in managing a large Federal grant. Some tentative themes relating to the influence of CCDP projects on the development and operation of grantee agencies were discerned from both project directors' and advisory board statements. These themes are discussed next.

Influences of CCDP on Grantee Agencies—Project Directors' Perspectives

Collaboration between CCDP projects and other community agencies has increased the participating agency staffs' levels of expertise, according to some project directors.. Both the grantee agency and participating agency staff have benefitted from training by CCDP staff and from the latter's experience in working with local low-income families. For example:

> Project G frequently is asked to provide technical assistance to other community agencies. One outcome of this project has been the cross-training that is offered between [the grantee and participating] agencies as part of the interagency agreements. This increased communication and understanding between agencies provides improved services to families and prevents families from falling through the cracks.

At least one project director reported that CCDP projects encourage the grantee agencies to be more responsive to the community's needs. For example:

> In response to the community, Project G has altered some aspects of its program. The grantee (a large university) has found it necessary to change the way it does business. In order to be responsive to a community-based project serving children and families, the university has developed new strategies, including accounting procedures to support emergency assistance, transportation, and child care needs. The university has found that Project G offers an opportunity to become more involved in the community, offers students a site for expanded learning opportunities, increases the awareness of needs and issues in the broader community, offers the university an avenue to help families, and is impacting the way services traditionally have been offered.

Influences of CCDP on Grantee Agencies—Advisory Boards' Perspectives

A review of advisory board statements indicated that board members believed that the CCDP projects they represented had a major influence on the development of the grantee agencies. For example, the Project U advisory board wrote:

> Project U also has had an important influence within the agency. Since the start of Project U, [the sponsoring agency] has jumped into a community leadership role in the local and state Family Support Movement. [The sponsoring agency] has opened two additional Family Support Centers [in nearby neighborhoods].

Project L, part of a grantee agency that largely works with traditional Hispanic families, was experienced in working with this population but tended not to seek out the assistance of, or attempt to help, other community agencies that did not have the same sensitivities toward this population. However, according to Project L's advisory board:

> Project L has been instrumental in fostering collaboration for various projects, grant proposals, training sessions, and the formation of a number of consortiums. Most recently, a joint proposal was developed with the [local] school district that would enable the school district to work with the community in nontraditional ways.
>
> The impact of Project L on its sponsoring agency has been that of fostering [from] within. Its [the CCDP project's] existence forced the sponsoring agency to take a new look at who they were and what they want to become. This will have a lasting impact on the community in that [the sponsoring agency] will be serving this community for many years to come.

The advisory board of Project G also believed that the CCDP project and its grantee agency had developed a mutually beneficial relationship that had and will continue to have a multilateral effect on the community and its low-income population. The advisory board provided the following example:

> A fourth view of success has developed from the imprint of Project G on its parent agency [a university hospital], and vice versa. The University Medical Center has embraced Project G wholeheartedly as reflected in its financial commitments [matching funds of nearly $300,000] and in its enthusiasm [sponsoring a holiday party]. On the other hand, the Medical Center sees Project G as a means to re-establish contact with the community, as a way to demonstrate its mission to help the needy, and as a conduit and bridge for the academic community and the "real" world. As America and the world struggles with the health care plan of the future, surely this dynamic and positive relationship between a prominent medical center and its community should be welcomed and nurtured. Clearly, this has been a "win-win" situation.

CONCLUSIONS REGARDING THE INFLUENCE OF CCDP ON THE COMMUNITY

CCDP projects were implemented in communities whose services networks had unique histories and characteristics. In broad terms, services networks were characterized as being either "coordinated" or "not coordinated." Over a 1- to 2-year period, the nature of these services networks sometimes changed in significant ways, and consequently, the perceptions of agency personnel about CCDP also sometimes changed. Although the period covered was too short to provide definitive conclusions, it appears that CCDP projects are facilitating services integration at both the service and systems levels. In some communities, the idea of cooperation and collaboration among service agencies was new, but once the potential of these ideas was perceived, many agency personnel embraced the goals and philosophy of CCDP. Community agency personnel were generally supportive of CCDP, despite some feelings of jealousy and fear that CCDP would rob existing agencies of scarce resources.

The ethnographers identified four main factors associated with the implementation and strengthening of an integrated service network: (1) case management; (2) an active and committed advisory board; (3) formal interagency agreements; and (4) a strong, supportive grantee agency.

Overall, CCDP projects had a positive impact on community service networks during the early stages of their operation, and recent reports by CCDP advisory boards and project directors suggest that CCDP continues to have a positive impact on families and on grantee agencies. As CCDP projects evolve and take more of a leadership role in the community, it is expected that the CCDP model increasingly will be replicated by building on its strengths. In the final report, an analysis will be provided of (1) the barriers faced by CCDP projects and (2) CCDP's role in fostering services integration.

The director at Project X summed up CCDP's overall effect on the local communities as follows:

> ...the project has had an impact on these communities. It has contributed to stronger economies, healthier families, and increased access to and sensitivity among other service providers. It has promoted the acquisition of knowledge and skills, increased family involvement and leadership in community activities, and demonstrated that families can change and become productive contributors to their communities.

Project directors observed that CCDP projects' interactions with, and effects on, the communities have been positive. They believe that CCDP projects' encouragement of integrative and collaborative service delivery—along with family, staff, and agency involvement in the communities—has facilitated the matching of many families' needs, problems, and goals with appropriate types and levels of services. The project directors' statements confirm the important role that CCDP projects have played in promoting changes in families and their communities.

Finally, the following statement, provided by the advisory board of Project W, sums up CCDP's impact on community service systems around the country:

> Since its inception, a consortia of human services, government, and business have collaborated to provide a comprehensive, integrated network of services to meet the needs of families. As a result of these collaborative efforts we have been able to provide Section 8 housing certificates, quality child development centers in two public

housing complexes, learning skills workshops to prepare individuals for postsecondary education, and job skills workshops for individuals looking for work.

More importantly, Project W has changed the way services are being delivered in [the] county. Human service organizations which once provided emergency services to individuals are linking these services to participants in self-sufficiency programs such as Project W. Agencies in [the community] are developing partnerships to meet the needs of targeted populations because of the results of Project W.

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Chapter 8. COST ANALYSIS

The cost analysis for this interim report is based on the Comprehensive Child Development Program (CCDP) budgets for Fiscal Year (FY) 1992.[1] FY 1992 was chosen as the basis for the analysis as it represents the most recent fully completed service year. Also, as explained in Chapter 4, by FY 1992 the CCDP projects had stabilized. During FY 1991 the grantees were still in the project's startup phase and facing the challenges common to new service delivery projects of the complexity and uniqueness of CCDP. By FY 1992 each of the grantees represented in this analysis were fully functional. In addition, this timeframe was chosen because it matches the timeframe used for both the feasibility analysis and process and impact evaluations.

The following parameters were established in order to achieve the objective of representing the costs to the Federal Government for operating CCDP during a fully functional service year:

- Purchases for equipment were annualized over the remaining 4 years of the grants. All expenditures for equipment, such as computers, vans, or copiers, were listed in the analysis at one-fourth of their purchase value.
- Research costs were not included in the analysis. Since CCDP is a demonstration project, each grantee is required to participate in data collection and reporting activities, a requirement that would not exist in a nonresearch demonstration program.
- Matching and in-kind contributions were not included in the analysis. These represent funding and services available through the parent grantees' organizations and community organizations, plus local and State governments.

CALCULATION OF CCDP COSTS

The total FY 1992 cost for each grantee was calculated by adding the Federal CCDP budget, subtracting the estimated research budget, and then subtracting the carry-over balance (COB) from the end of FY 1992, as shown below:

Total Cost = Federal budget - estimated research budget - COB at the end of FY 1992

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[1] A unit cost system for measuring both Federal- and non-Federal-derived costs currently is being field-tested. The data from this system will be used in the final report.

The Federal budget includes money budgeted in FY 1992 plus any COB's from funding years prior to FY 1992 plus any one-time funding awarded to grantees, as shown below:

Federal Budget = 1992 new Federal money + COB 89 + COB 90 + COB 91 + one-time money

The research budget includes an estimate of each staff member's time dedicated to research activities, multiplied by his/her salary plus other costs associated with research (see the research costs section for more details), as shown below:

Research Budget = summation of (specified percent)*(salary) + other estimated research costs

A carry-over balance for FY 1992 includes Federal funds not spent in FY 1992 that were carried over to the FY 1993 budget.

Research Costs

Estimated research costs include expenses that grantees would not incur if CCDP was not a research demonstration project. The two main sources of research costs excluded from this analysis were (1) the cost of the project's ethnographer and (2) the cost associated with operating the CCDP Management Information System (MIS).

The CCDP MIS, an information collection and reporting system, was designed by CSR, Incorporated, and Information Technology International in conjunction with the Administration on Children, Youth and Families (ACYF) and the grantees as a primary means for collecting data for research. The CCDP MIS includes a set of data collection instruments (i.e., paper forms) which contain a set of data elements defined by the research and management needs of CCDP. The information collected on these forms is entered and stored in an automated system and available for quarterly submissions to ACYF and for the grantee's local reporting needs. Although the CCDP MIS is a helpful tool for grantees to use in managing their projects and understanding the needs of the population they are serving, the amount of data collected and the data quality assurance required far exceed the data needs expected by a typical service delivery program.

The estimated costs associated with research that were excluded from this cost analysis include the following:

- Specified percentage of time a staff person spends on research activities (see Exhibit 8-1 following this page);
- Fringe benefits associated with the specified percentage of staff salary;

Exhibit 8-1

Estimated Percentage of Staff Time Associated With Research

Staff	Percentage of Time	MIS/Research Responsibilities
Project Director	10%	Review quality of data submitted to ACYF
Data Manager	70%	Track forms Perform quality assurance Enter data Check data for accurate data entry Generate MIS reports Train staff on MIS forms
Data Entry Clerk	70%	Enter data Identify coding errors Generate reports
Family Advocates	20%	Document enrollment and changes of address Document services that they provide to CCDP families Document subsidies and financial assistance information Document pregnancies, births, and deaths
Family Services Coordinator	15%	Oversee data collection activities Review forms to assure that they are coded correctly Compare case notes against completed MIS forms to assure completeness
Early Childhood Education Specialist	5%	Record developmental screening and assessment information
Early Childhood Education Coordinator	15%	Collect attendance information for all center-based ECE and child care activities Assure that home-based ECE, developmental screening, and assessment information are recorded correctly
Health Coordinator	15%	Collect health data Record health data Monitor and track health data
Education/Training Coordinator	10%	Collect, record, and track adult education and training information
Employment Specialist	10%	Collect and track family member employment data
Mental Health Specialist	10%	Collect, record, and monitor mental health data
Ethnographer	100%	Prepare three reports each year
Teachers	5%	Track attendance for center-based ECE and assist in assuring information in MIS is accurate
Male Services Coordinator	5%	Document services that he/she provides to CCDP family members

- Comparison group stipends;
- Stipends for program families;
- Seventy percent of computer-related costs (e.g., hardware, software, maintenance, and consultant costs); and
- Any other research costs, such as case studies (including local research activities).

The estimated percentages of staff time associated with research are provided in Exhibit 8-1. The descriptions of staff and activities associated with research represent typical situations across the 21 grantee sites. Each grantee has developed its own service delivery and coordination model; therefore, MIS data collection and reporting activities will vary among the sites.

Matching Funds

Each local CCDP grantee is funded through a variety of sources. Federal funding is the most significant source; however, other funding sources play an important role in the operation of CCDP. Parent agencies, local and State governments, and community agencies show their support for CCDP by providing matching funds or in-kind contributions. Matching funds and in-kind contributions have not been included in this cost analysis for several reasons, including the following:

- The objective of this analysis is to show the estimated cost borne by the Federal Government to operate a CCDP grant.
- The value of in-kind contributions is difficult to determine in an objective manner.
- Often grantees do not report all of their in-kind contributions because it is not a program requirement to do so.

Cost Analysis

Exhibit 8-2 following the next page lists CCDP costs calculated for each site based on the FY 1992 budget obtained by following the method discussed in the section Calculation of CCDP Costs.

As seen in Exhibit 8-2, the total Federal nonresearch funding for FY 1992 was $16,929,349. The average Federal nonresearch cost per family in FY 1992 was $8,243, while the average cost per family member was $2,137. Exhibit 8-3 depicts the annual Federal nonresearch cost per site, which ranges from $1,408,340 to $440,717. Exhibit 8-4 presents the annual Federal nonresearch cost per family across sites, which ranges from $13,413 to $4,592. Exhibit 8-5 following this page presents the annual Federal nonresearch cost per family member across sites, which ranges from $4,023 to $1,140.

DISCUSSION OF COST ANALYSIS

To identify the factors contributing to cost variations across sites, a preliminary comparison among sites was performed. The following factors appeared to affect cost differences the most:

- Child care;
- Transportation systems; and
- Population density.

Each of these factors is discussed below.

Child Care

Child care costs are equally high in both urban and rural areas. Most sites provide CCDP-funded vouchers to families to meet their child care needs when funds are not available through other funding streams. For some sites, child care facilities are either limited or do not meet the Head Start Performance Standards. The sites that have limited access to child care centers have developed their own centers. In these cases, child care costs are higher simply because the sites have increased personnel and operating costs. The shared element between urban and rural sites is that, as CCDP families move toward self-sufficiency, child care needs increase because parents either begin working or are involved in degree and/or job training programs. Child care costs will increase according to the demand for services.

Transportation Systems

Rural sites have especially high transportation costs for both families and family advocates who travel long distances to visit families at their homes. Since public transportation systems are lacking in rural areas, the CCDP projects make transportation available to CCDP families through taxi vouchers, leasing of vans, and the hiring of drivers to transport CCDP families. Thus, the operating and personnel costs increase for these sites.

Population Density

The cost per family in rural sites is greater than in urban sites, primarily because rural sites serve a smaller number of families. However, the cost per family member is higher in urban sites because the average number of members in each family is higher in rural sites than urban sites.

Exhibit 8-2

Federal CCDP Cost Analysis Summary Information for FY 1992

Code	No. of Families[1]	No. of Family Members	Children Under Age 5	Federal Budget[2]	Research Costs	COB From End of FY 1992	Total Cost[3]	Total Costs Per Family	Total Cost Per Member
B	111	478	197	$ 913,712	$125,240	$243,443	$545,029	$4,910	$1,140
D	116	557	223	$1,023,929	$170,492	$83,308	$770,129	$6,639	$1,383
V	110	521	182	$856,398	$144,169	$0	$712,229	$6,471	$1,367
P	161	627	220	$1,269,805	$136,428	$394,085	$739,292	$4,592	$1,179
L	120	510	164	$925,434	$129,719	$13,596	$782,119	$6,518	$1,534
*R	89	332	126	$665,995	$141,663	$43,474	$480,858	$5,403	$1,448
J	109	483	203	$1,004,739	$116,113	$0	$888,626	$8,153	$1,840
G	110	430	177	$1,105,356	$231,961	124,863	$748,532	$6,805	$1,741
H	110	366	161	$1,039,364	$114,997	$185,115	$739,252	$6,720	$2,020
*X	59	232	97	$633,898	$136,657	$56,524	$440,717	$7,470	$1,900
C	93	369	130	$1,015,748	$170,084	$0	$845,66	$9,093	$2,292
K	109	458	147	$1,263,010	$181,526	$73,744	$1,007,740	$9,245	$2,200
I	103	360	151	$965,910	$119,028	$0	$846,882	$8,222	$2,352
N	115	430	164	$1,188,862	$157,451	$68,000	$963,411	$8,377	$2,241
W	118	429	185	$1,202,850	$109,030	$136,000	$957,820	$8,117	$2,233
*S	58	220	93	$858,313	$102,811	$234,238	$521,264	$8,987	$2,369

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Exhibit 8-2 *(continued)*

Code	No. of Families[1]	No. of Family Members	Children Under Age 5	Federal Budget[2]	Research Costs	COB From End of FY 1992	Total Cost[3]	Total Costs Per Family	Total Cost Per Member
Q	107	329	130	$1,102,399	$138,152	$57,000	$907,247	$8,479	$2,758
*E	58	220	89	$771,530	$102,574	$29,000	$639,956	$11,034	$2,909
*A	293	293	106	$1,045,899	$114,210	$226,879	$704,810	$12,152	$2,405
U	105	394	147	$1.553,511	$128,020	$17,151	$1,408,340	$13,413	$3,575
M	104	318	148	$1,446,600	$167,168	$0	$1,279,432	$12,302	4,023
Total	2,123	8,356	3,240	$21,853,262	$2,937,493	$1,986,420	$16,929,349	$173,105	$44,909
Average	101	398	154	$1,040,632	$139,881	$94,591	$806,159	$8,243	$2,137

* Rural site

[1] Number of families, family members, and children under age 5 were determined using data from the third quarter FY 1992.

[2] All dollar amounts are estimated numbers

[3] Total cost = Federal budget - estimated research budget - COB at the end of FY 1992

Exhibit 8-3

Annual Federal Nonresearch Cost Per Site

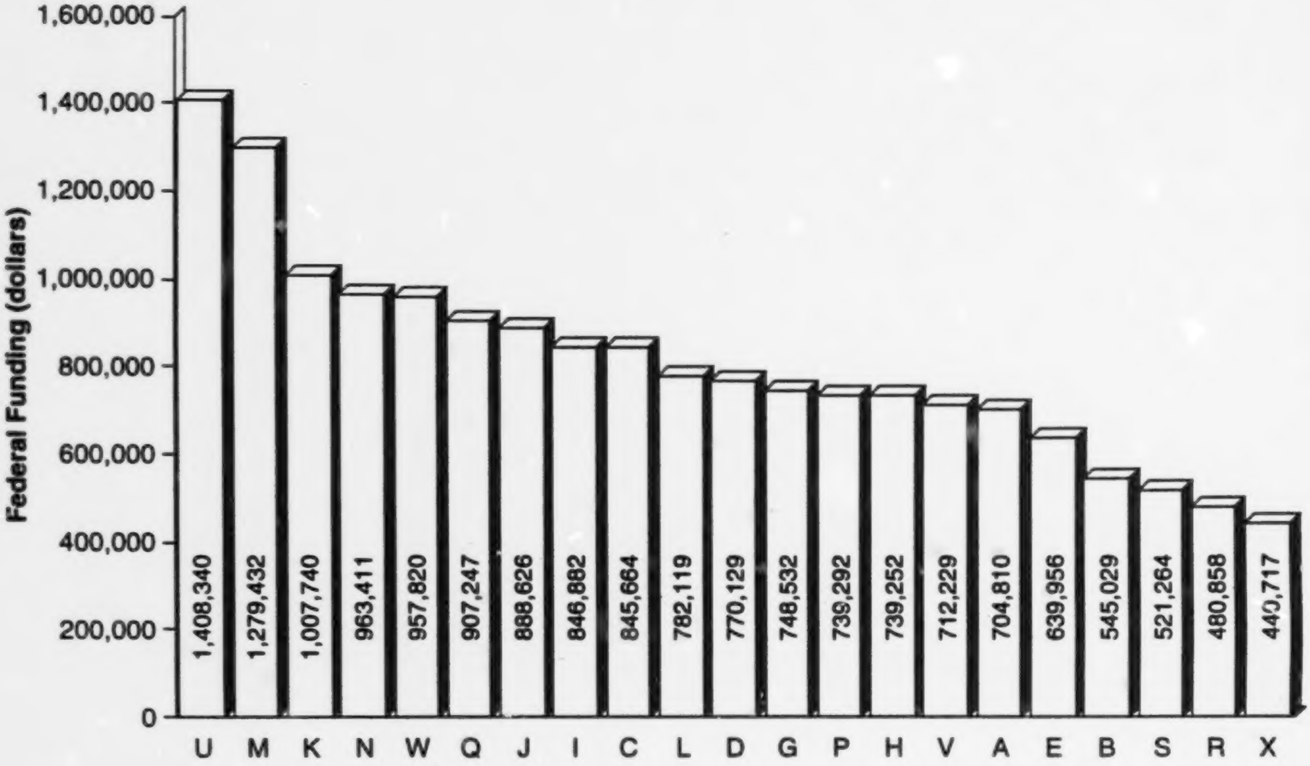

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Exhibit 8-4

Annual Federal Nonresearch Cost Per Family

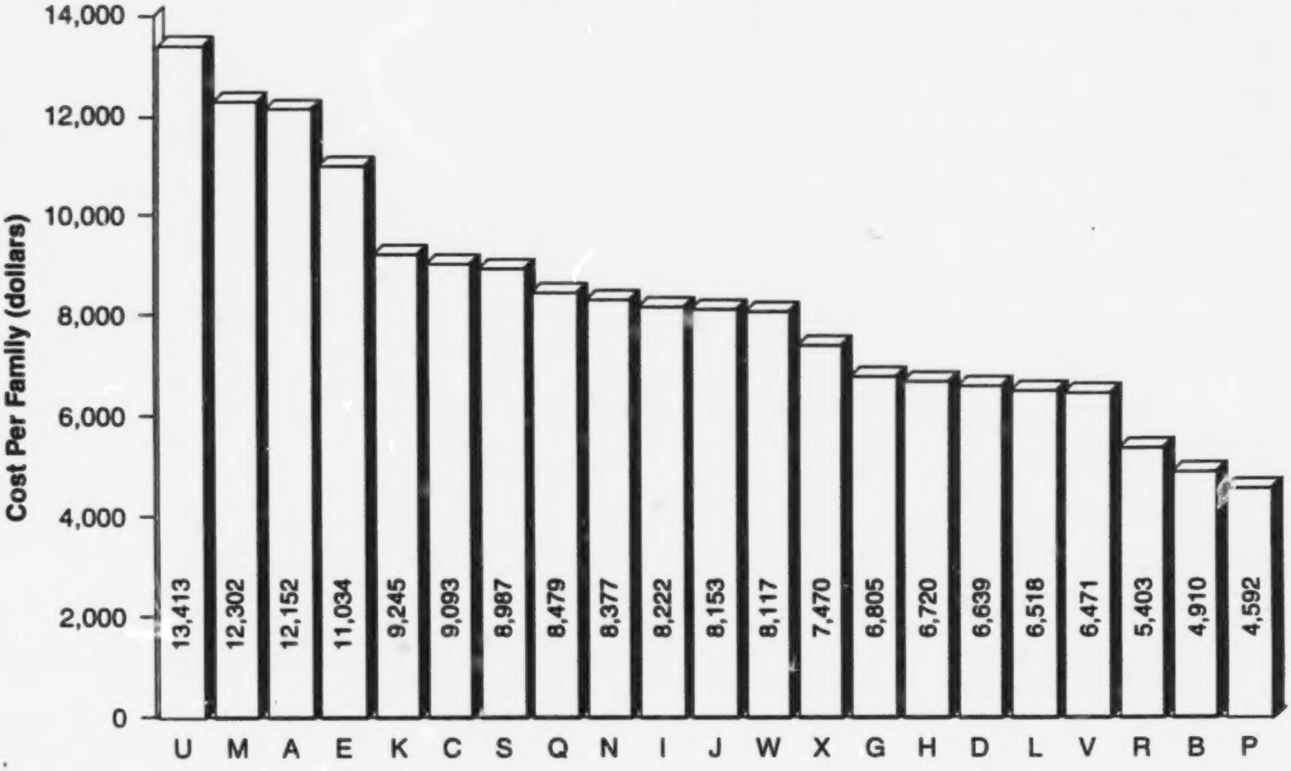
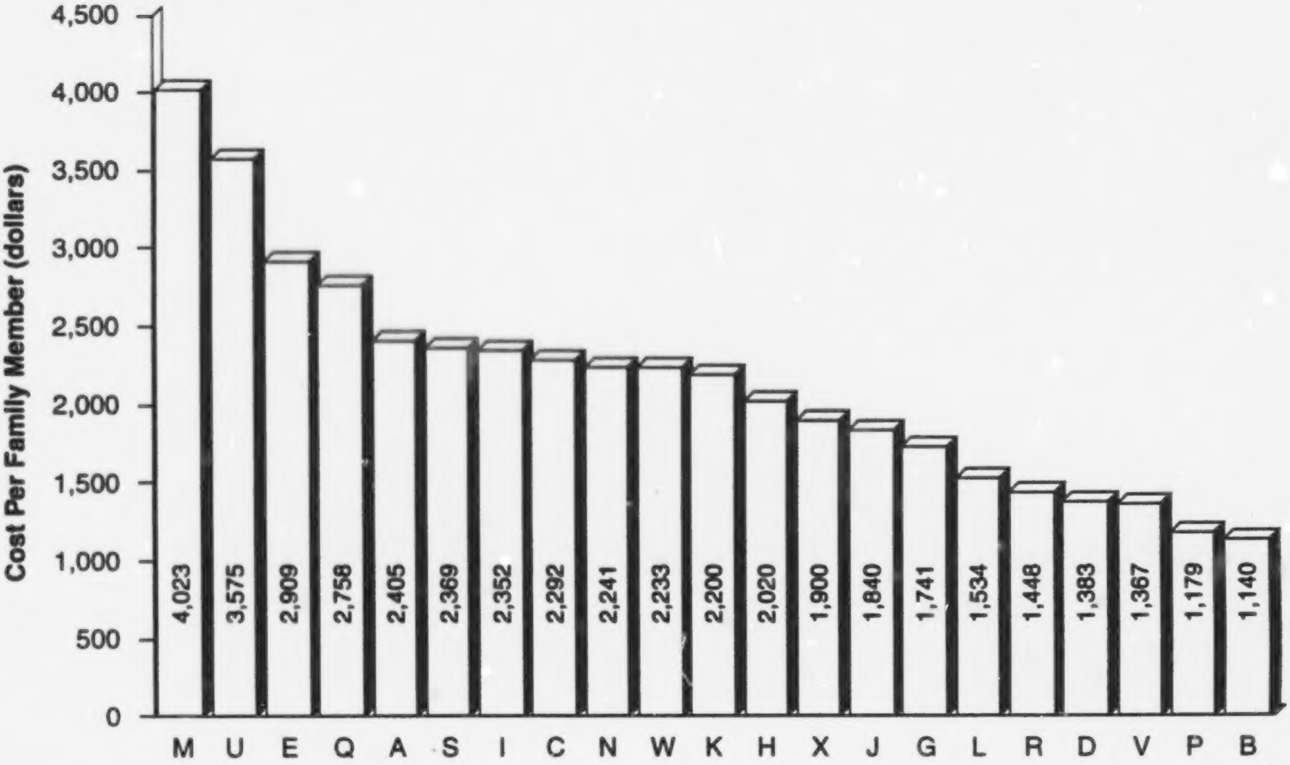


Exhibit 8-5

Annual Federal Nonresearch Cost Per Family Member



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PART III. IMPACT EVALUATION

Chapter 9. Impact Evaluation Conceptual Framework and Study Methods

Chapter 10. Changes in Service Utilization for Families in the Impact Evaluation

Chapter 11. Effects on Mothers, Fathers, and Children

Chapter 9. IMPACT EVALUATION CONCEPTUAL MODEL AND STUDY METHODS

This chapter sets forth the research questions, conceptual model, and study design of the Comprehensive Child Development Program (CCDP) impact evaluation. Also described are the areas of measurement selected for the study, data collection progress to date, and the data analysis strategy.

RESEARCH QUESTIONS FOR THE IMPACT EVALUATION

The CCDP national impact evaluation is a 5-year study of about 4,400 families in 21 of the 24 original CCDP projects.[1] The evaluation is designed to address four major issues:

1. The effects of CCDP on children's cognitive development, social-emotional development, and physical health;
2. The effects of CCDP on parents' and families' economic self-sufficiency, life management skills, and psychological and physical statuses;
3. Whether the effects of CCDP vary with mediating variables, such as family or site characteristics, program model, differences in the quantity or quality of program services provided, or length of participation in the program; and
4. The per family costs of CCDP and how the program's effects compare with these costs.

This interim report focuses on the first two issues listed above. The final report on the impact evaluation will address all four research areas.

CONCEPTUAL MODEL FOR THE IMPACT EVALUATION

The following discussion summarizes the conceptual model for assessing the short-term effects of CCDP on children, parents, and their families, that is, the effects measured on children at 2 years of age and on their parents and families after CCDP had been operating for 2 years. Also discussed are hypotheses about the types of effects that are to be expected and when.

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[1] Two projects were dropped from the evaluation because of problems experienced by local staff in conducting the process of random assignment and a third project was not included due to limitations of resources for evaluation purposes.

The model has been developed in order to advance our understanding of CCDP and to provide a forum for discussion about the ways in which CCDP projects produce their effects. However, it should be remembered that the main analytic approach for the evaluation is a pretest-posttest impact model that relies on random assignment to ensure comparability of program and control groups—this is not a study that relies on causal modeling to determine program effects or relationships among sets of effects. Furthermore, the reader should remember that CCDP was envisioned as a 5-year project and that the discussion presented here only represents effects stemming from the early part of the program. Additional data are being collected on children as they reach ages 3 and 4 (as well as on their parents), and findings from additional analyses will be included in the final report to Congress.

The conceptual model for this evaluation, as seen in Exhibit 9-1 following this page, is based on the overall hypothesis that by providing or coordinating the provision of a range of health, social, and educational services for children and their parents, CCDP will increase the appropriate and timely use of these services among families participating in the program. Increases in the utilization of services then are hypothesized to lead to a series of short-term effects for families, parents, and their children. Finally, attainment of these short-term effects is posited to lead to positive longer term economic and educational changes in the lives of parents and their children.

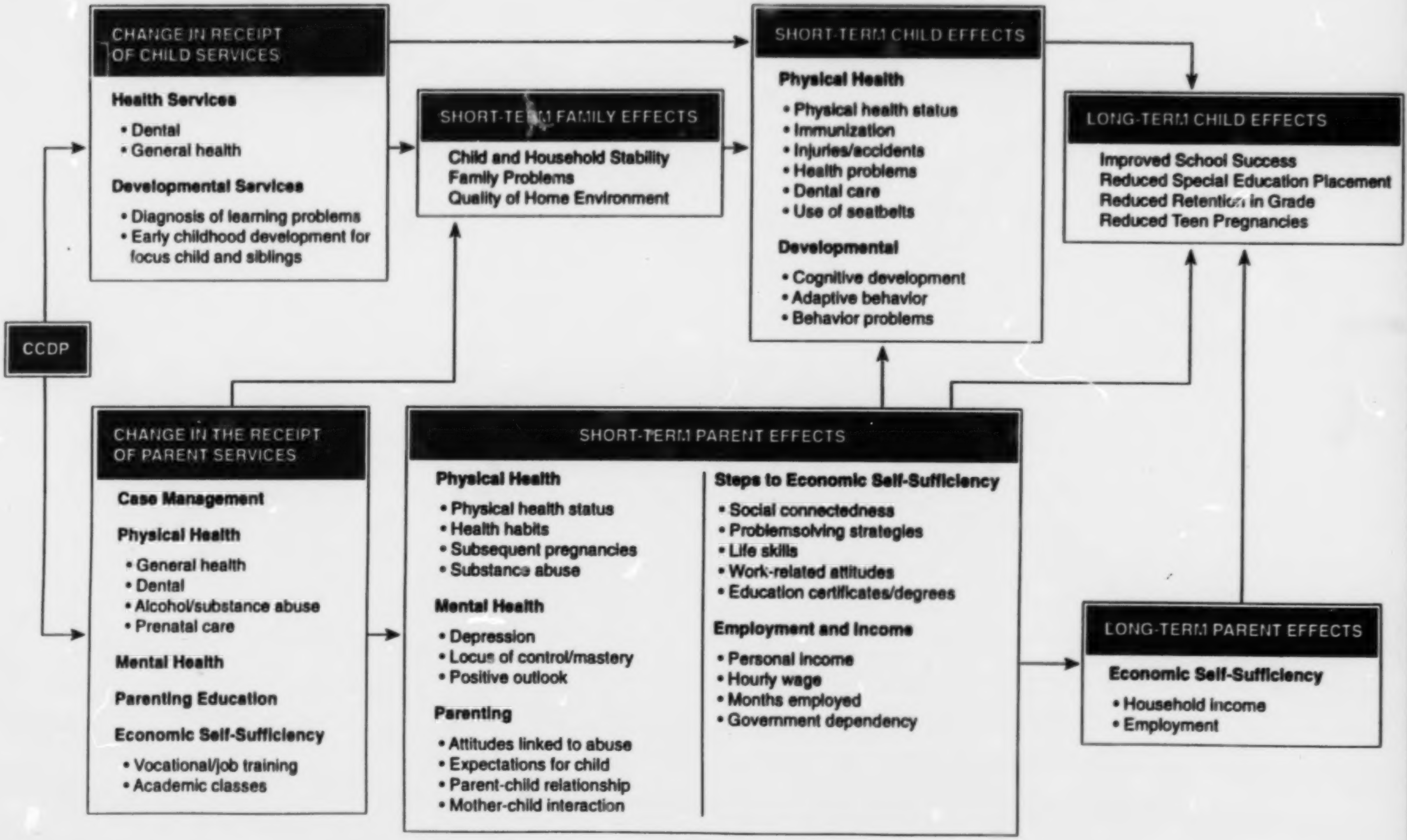
Hypothesized Changes in Services Utilization

CCDP projects all adhere to a common service delivery model in that they strive to coordinate existing community-based services in order to reduce overlap while, at the same time, using their own resources to fill the existing gaps in local service delivery systems. The division of responsibility for direct-service provision (CCDP versus other local service providers) thus depends to a very great extent on the availability of social, educational, and health services in the local community.

Case management is a primary ingredient in service delivery that cuts across all CCDP projects. CCDP service delivery begins with family-focused case management, and projects generally use a model in which each family is assigned a case manager who coordinates all activities. While the titles (e.g., case manager, caseworker, social worker, family worker, family advocate, etc.) and exact functions of the case managers vary from project to project, all projects conduct a family needs assessment and prepare a family service plan. Among other functions, case managers make frequent home visits, help deal with family crises, and, in some projects, provide child development training. It is hypothesized that CCDP's family-focused case management approach to service delivery will result in greater access to, and utilization of, a comprehensive range of child, parent, and family services for CCDP families as compared to control group families.

Exhibit 9-1

Model of CCDP Effects


CCDP
CHANGE IN RECEIPT OF CHILD SERVICES
Health Services
• Dental
• General health
Developmental Services
• Diagnosis of learning problems
• Early childhood development for focus child and siblings
SHORT-TERM FAMILY EFFECTS
Child and Household Stability
Family Problems
Quality of Home Environment
SHORT-TERM CHILD EFFECTS
Physical Health
• Physical health status
• Immunization
• Injuries/accidents
• Health problems
• Dental care
• Use of seatbelts
Developmental
• Cognitive development
• Adaptive behavior
• Behavior problems
LONG-TERM CHILD EFFECTS
Improved School Success
Reduced Special Education Placement
Reduced Retention in Grade
Reduced Teen Pregnancies
CHANGE IN THE RECEIPT OF PARENT SERVICES
Case Management
Physical Health
• General health
• Dental
• Alcohol/substance abuse
• Prenatal care
Mental Health
Parenting Education
Economic Self-Sufficiency
• Vocational/job training
• Academic classes
SHORT-TERM PARENT EFFECTS
Physical Health
• Physical health status
• Health habits
• Subsequent pregnancies
• Substance abuse
Mental Health
• Depression
• Locus of control/mastery
• Positive outlook
Parenting
• Attitudes linked to abuse
• Expectations for child
• Parent-child relationship
• Mother-child interaction
Steps to Economic Self-Sufficiency
• Social connectedness
• Problemsolving strategies
• Life skills
• Work-related attitudes
• Education certificates/degrees
Employment and Income
• Personal income
• Hourly wage
• Months employed
• Government dependency
LONG-TERM PARENT EFFECTS
Economic Self-Sufficiency
• Household income
• Employment

The impact evaluation has measured rates of services utilization through face-to-face recall interviews with the mothers. The following areas were addressed with the mothers: nature and frequency of contact with case managers, physical health services (e.g., general health, dental, alcohol/substance abuse, and prenatal care), mental health services, parenting education services, and services designed to enhance economic self-sufficiency (e.g., academic classes and vocational/job training). For children, mothers also were asked to report on general health and dental services for the focus child, early childhood development services for both the focus child and for siblings, and services for diagnosing learning problems.

Hypothesized Short-Term Effects on Parents

Mothers living in poverty may suffer a variety of psychological consequences including low self-esteem, depression, lack of hope for the future, lack of any sense of personal empowerment, low aspirations, and social isolation. They may have health problems, such as untreated chronic illnesses and anemia stemming from poor nutrition, and are increasingly at risk for substance abuse. The combination of unfinished education, possible lack of parental role models, and absence of extensive social support networks often leaves them with inadequate life management skills, including difficulty in making decisions, inability to manage limited budgets, and limited understanding of what it takes to be a good parent. Facing difficulties, both practical and motivational, in completing their education or acquiring job skills, they may be unable to achieve even limited economic self-sufficiency.

CCDP is working to alleviate these problems through provision or coordination of the services described earlier. Anticipated short-term outcomes for parents include positive changes in physical health (e.g., improved health status and health habits and an increase in appropriate behaviors with respect to subsequent pregnancies), improvements in their mental health (e.g., lessened depression, an improved sense of control over their lives, better decisionmaking abilities, and a more positive outlook on life), enhanced parenting skills (e.g., reductions in attitudes that have been linked to abusive or neglectful behaviors, increased expectations for children, improved parent-child relationships, and enhanced parent-child interactions), improved chances for economic self-sufficiency (e.g., increased social connectedness; improved problemsolving strategies and life skills; better work-related attitudes; and an increase in attainment of education certificates, diplomas, or degrees), and better employment and income (e.g., reduced government dependency and increased personal income, hourly wages, and months employed).

Hypothesized Short-Term Effects on Families

Poverty places severe strains on family relationships, including an increased likelihood of conflict with one's spouse, spousal abuse, and marital dissolution. Frequently, if the child's father lacks job prospects, marriage is deferred or not entered into. The family may face constrained resources in terms of income, housing, food, and transportation, as well as inadequate or totally absent social supports. Dangerous neighborhoods often place additional stress on the family, and poor schools fail to offer needed support.

It is hypothesized that the comprehensive services offered by CCDP projects will, over time, be able to alleviate some of these family-level problems by increasing the stability of the child's life as well as the stability of the household, by reducing family problems, and by increasing the family's ability to nurture the child's development.

Hypothesized Long-Term Effects on Parents

CCDP hopes to achieve its hypothesized short-term effects for parents so that, in the long term, fundamental economic and social alterations are made in the lives of participating parents. In particular, long-term effects on parents are hypothesized to include a continuation of positive short-term effects (e.g., improved physical and mental health) and achievement of economic self-sufficiency or, at least, decreased reliance on Federal aid.

It is not clear when such long-term effects are expected to occur. They will be measured during the course of the proposed evaluation. However, the absence of effectiveness on long-term outcomes over the course of this evaluation is not evidence, in and of itself, that CCDP is unable to achieve its long-term outcomes. Assuming that CCDP has been able to achieve its anticipated effects on services receipt by parents and on short-term effects for parents, it is reasonable to continue a search for long-term effects past the end date of this study. While some research has been conducted on the long-term effects of intensive interventions on children, much less research has been conducted on the long-term effects of intervention programs on adults, and hence there is little guidance in planning a long-term study. In the absence of other input, it may well be necessary to follow adults for another 2 to 10 years to determine whether CCDP's intended long-term effects manifest themselves.

Hypothesized Short-Term Effects on Children

For infants and young children, the immediate consequences of poverty are increasingly severe. High levels of infant mortality and morbidity, prematurity, and impaired health status all have been associated with infants born into poverty. Young children living in poverty are less likely to see a pediatrician, to receive immunizations, or to receive dental care—all important steps to ensure future healthy growth. Adverse birth outcomes often result in developmental delay, behavior problems, and inadequate preparation for school.

As children enter adolescence, they enter the cycle of poverty-related consequences that already may have been experienced by their parents, such as lower school achievement and unfinished education, early sexual activity leading to teen pregnancy, substance abuse, delinquency, and a higher incidence of death from accidents or homicide.

CCDP has been designed to change this pattern by providing a comprehensive range of services directly to children and their families. Anticipated short-term outcomes for children include improved physical health (e.g., better health status and reduced health problems, appropriate immunizations, reduced injuries and accidents, increased dental care, and increased use of seatbelts) and improved developmental progress (e.g., positive cognitive development, reduced behavior problems, and appropriate adaptive behavior).

Hypothesized Long-Term Effects on Children

Long-term effects on children, primarily related to improved success in school, are hypothesized to result from achievement of CCDP's short-term outcomes for children, as well as from achievement of CCDP's short-term and long-term effects for parents.

Many studies have shown that early childhood education programs can produce short-term effects on children's school readiness (Layzer et al., 1990). Studies also have shown that these effects may "fade out" over time, so that differences are not observed past the early elementary grades (Lazar et al., 1977), although recent research has disputed the reasons for the observed fadeout of effects (Barnett, 1993). Finally, some studies (Lazar et al., 1977; Berreuta-Clement et al., 1984) have found evidence of long-term effects in noncognitive areas. These effects manifest themselves in later grades and throughout the lives of children who participated in high-quality preschool programs.

CCDP hopes to change this potential pattern of fadeout of cognitive effects and to continue the promising pattern of long-term effects in noncognitive areas by providing a coordinated package of comprehensive services to young children (from infancy to compulsory school age) and their families that ought to lead to appropriate short-term effects and, subsequently, to improved chances for long-term effects for children as measured by later success within the school environment. Specific measures of long-term success through the early elementary school years might include, among others, teachers' ratings of social and emotional behaviors, socialization, and academic achievement; grades; rates of placement in special education, remedial, or other academic programs; and rates of grade retention/advancement. Areas that might be examined for even longer term effects include reductions in teen pregnancies, reductions in incarcerations, increases in employment rates, and increases in earnings.

Expected Timing of CCDP's Effects

As was probably understood from the above discussion, the effects of CCDP are anticipated to occur in a specific order: Changes in services utilization are hypothesized to occur initially; followed by short-term effects on parents, their children, and families; and finally by long-term effects on program participants. In addition, short-term effects on families are expected to be mediated by effects on parents, and short-term effects on children are expected to result both directly, from increased services utilization, and indirectly, as a result of early effects on parents and families. That is, short-term effects on parents and on families are expected to interact with the provision of child-level services to lead to enhanced child-level effects. To the extent that effects on parents are not achieved, it is possible that child-level and family-level effects will be somewhat depressed.

Timing of Services Utilization Effects

Changes in services utilization should occur in the early stages of program implementation and should be measurable within the first year of project startup. Because families were randomly assigned, both the families in CCDP and in the control group should have similar levels of need for various types of services. It is hypothesized that CCDP families will evidence increased receipt of many different types of services and that early increases in services receipt should be seen as a positive, rather than a negative, occurrence. Most importantly, it is expected that CCDP mothers will be more likely than control group mothers to have received case management services but that the need for case management services will decrease over time as mothers become more self-reliant.

For developmental/educational services a higher percentage of CCDP children than control group children are hypothesized to participate in early childhood development programs and a higher percentage of CCDP mothers should participate in parenting education and academic programs. These increased service levels for children should persist until they enter school. For mothers, participation in educational programs may diminish over time, as degrees or certificates are attained.

What to expect in terms of receipt of physical health services is somewhat more complicated. It is expected that CCDP will increase the use of some kinds of health services, while decreasing the use of other kinds. In particular, CCDP children ought to be more likely than control group children to have regular visits to a dentist and a doctor (for preventive health care). These increased service levels ought to persist throughout the life of CCDP. CCDP children may be expected to use fewer hospital services than control group children because their health should be better attended during regular doctor's visits and because they are expected to experience fewer injuries.

CCDP mothers ought to be more likely than control group mothers to use mental health services and to use substance abuse services. Because they are randomly assigned, mothers in the two groups ought to be equivalent in terms of their service needs, and increased use of mental health or substance abuse services can be attributed to CCDP making mothers more aware of their problems and more willing to work toward solving them. However, mental health services and substance abuse services should work to alleviate these problems, and over time (as their mental health and physical health improves), CCDP mothers ought to use less of these services.

Timing of Short-Term Effects

The timing of CCDP's expected short-term outcomes for parents, families, and children is difficult to anticipate. A reasonable, though untested, expectation is that CCDP should be able to produce some of its anticipated short-term effects within a 1- to 2-year time period. These relatively early outcomes might include short-term effects on parenting skills, such as improved mother-child relationships and interactions, increased expectations for the child, and a decrease in abusive and neglectful behaviors on the part of mothers; short-term effects on steps to enhance families' economic self-sufficiency, such as improved work-related attitudes, better life skills, and better problemsolving strategies; and perhaps short-term effects on the home as an environment that fosters children's development. All of these effects should persist throughout the life of CCDP.

In the short run, it is possible that higher percentages of CCDP mothers than control group mothers will receive Federal benefits. This is because CCDP should act to ensure that participating mothers receive their entitled benefits, and while the long-run aim of CCDP may be to reduce Federal dependency, the program is expected to have the short-run effect of increasing participation in Federal programs.

Changes in other more complex domains—such as the physical health of parents and children, children's development, and employment and income—require comprehensive service delivery over a longer period of time and would not be expected to occur until somewhat later. Although some impacts are expected to be evident at the completion of 2 years of CCDP service delivery, other effects may not be detected until many years later (e.g., academic success through the high school years, reductions in juvenile delinquency, and reductions in teen pregnancies).

Timing of Long-Term Effects

The measurement of CCDP's long-term effects that extend beyond the 5-year duration of the current CCDP projects is outside of the scope of this impact evaluation. Assessment of improvements in school success must wait until CCDP children reach elementary school (and beyond), while reductions in teen pregnancies, and other indicators of reduced risk, cannot be measured until even later. The same holds for long-term effects on parents—substantial improvements in household income and employability are unlikely to manifest themselves during the term of this evaluation.

STUDY DESIGN OF THE IMPACT EVALUATION

The impact evaluation is designed to allow experimental comparisons over time of CCDP families with a randomly assigned control group with respect to child, parent, and family outcomes. Exhibit 9-2 following this page summarizes the design. The experimental nature of the research design means that the evaluation will be able to provide strong evidence with respect to questions about program impacts.

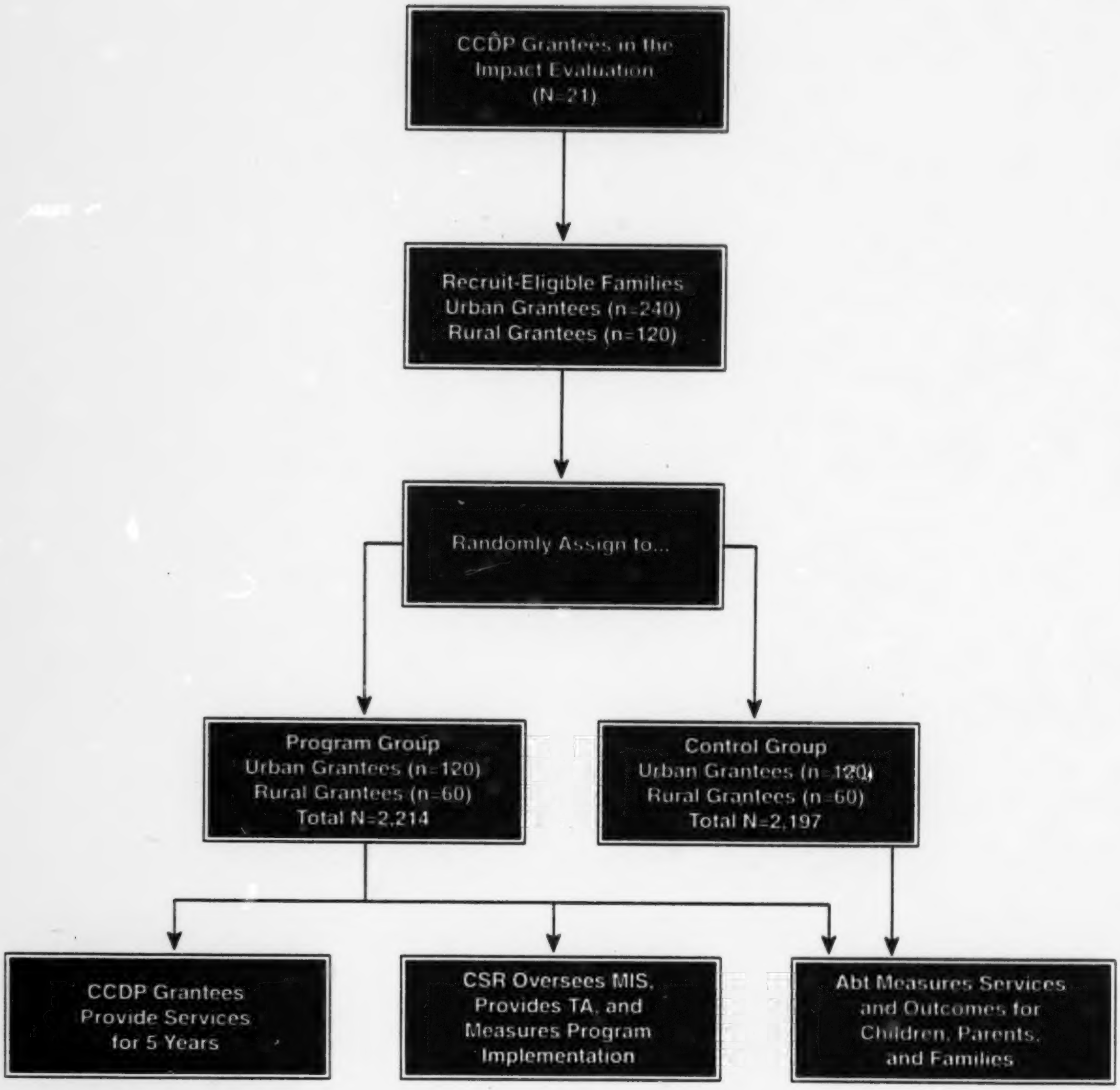
The CCDP program announcement (*Federal Register*, 1988) included language stating that applying projects would have to be willing to recruit more families than could be served and then to randomly assign those eligible families to program and control groups. The CCDP eligibility guidelines specify that each family must, at the time of enrollment, meet the following criteria: (1) have income below the Federal poverty guidelines, (2) include a pregnant woman or include a child under age 1 (i.e., the focus child), and (3) agree to participate in CCDP activities for 5 years.

CCDP grantees were selected, in part, on the basis that they had a sufficiently large eligible population to support a randomized study in which potential program participants would be recruited and randomly assigned to one of three groups: (1) a program group, (2) a control group, or (3) a replacement group (which is not used in the evaluation but which is important in terms of providing a group of families that can be used by CCDP projects to replace program dropouts). Each prospective grantee was told that the group of recruited families had to be proportionately representative of the low-income population of the grantee's recruitment area in terms of ethnicity and age of the primary caretaker. Grantees in urban areas were asked to recruit 360 eligible families at the start of the program (120 to participate in the program, 120 for the control group, and 120 for the replacement group), while grantees in rural areas were asked to recruit 180 families (60 for each of the three groups).

The impact evaluation is being conducted in 21 of the original 24 CCDP projects. All originally assigned program and control families in the 21 CCDP projects participating in the impact evaluation (about 2,200 in each group) are included in the overall evaluation sample that will be used for group comparisons, regardless of their actual level of participation in the CCDP projects. Thus, there likely will be some program families for whom few, if any, services were provided, other families who received a moderate amount of services, and still other families who participated fully in CCDP.

Exhibit 9-2

CCDP Evaluation Design


CCDP Grantees in the Impact Evaluation (N=21)
Recruit-Eligible Families
Urban Grantees (n=240)
Rural Grantees (n=120)
Randomly Assign to...
Program Group
Urban Grantees (n=120)
Rural Grantees (n=60)
Total N=2,214
Control Group
Urban Grantees (n=120)
Rural Grantees (n=60)
Total N=2,197
CCDP Grantees Provide Services for 5 Years
CSR Oversees MIS, Provides TA, and Measures Program Implementation
Abt Measures Services and Outcomes for Children, Parents, and Families

(For the final report, additional analyses will examine the differential effectiveness of length of participation in the program.)

Because CCDP intends to provide services to the same families for several years, until the focus children enter school, the evaluation is measuring the impact of the program over time on focus children, their mothers, and their families. Within each family, the development of the focus child is repeatedly measured—at 24, 36, and 48 months of age. Measures of services receipt and outcomes for mothers and families are taken annually at the same time as child measurements.

THE RANDOM ASSIGNMENT PROCESS

To determine which families would be enrolled as program families and which as control group families, the Administration for Children, Youth and Families (ACYF) indicated its preference that grantees use a random assignment procedure. Grantees were allowed to propose alternative assignment procedures if they could ensure that the two groups would be equivalent. The contractor responsible for the process evaluation and CCDP's management information system (MIS)—CSR, Incorporated—also was responsible for monitoring the recruitment and random assignment of families across the sites.

All of the grantees chose to use a random assignment procedure to assign families. However, projects differed on the random assignment procedure used, on whether the project or CSR did the random assignment, and on whether the random assignment was to the three groups (program, control, and replacement) or to two groups only (program and control).

In practice, most projects recruited and assigned families in multiple waves before reaching their enrollment goals. CSR proposed a random assignment procedure for projects to follow. Fourteen of the twenty-one projects participating in the impact evaluation used the CSR procedure; for three of these projects, CSR did the actual assigning of families. The remaining seven programs used a variety of procedures for assigning families randomly to groups. All of these procedures were approved in advance by CSR. A detailed account of recruitment procedures, the random assignment process, and the results of the process can be found in Appendix C of the second annual report from this evaluation (St. Pierre, Goodson, and Layzer, 1992).

The impact evaluation sample includes any families who were both assigned to the program or control group and notified of their assignments. This includes families who agreed to participate in the program as well as families who dropped out at any point immediately after being informed of their assignment. In contrast to the CCDP projects who are able to terminate families who are not actively participating, the evaluation team cannot exclude program families who are no longer actively participating or receiving services; the evaluation team must work hard to keep all control families in the evaluation as well. Keeping all families as part of the impact evaluation sample is crucial to maintaining the strength and integrity of the research design. If substantial numbers of families are lost from the sample, the program and control groups may no longer be statistically comparable, leading to potential bias in estimated program effects. Families that were assigned to a group but were not enrolled, either because they were determined to be ineligible or because they could not be located for notification of assignment, were not included in the impact evaluation sample.

Comparability of Program and Control Groups

The fact that the CCDP projects followed an appropriate randomization process is a critical element in the implementation of the impact evaluation. To assure readers that the randomization did, in fact, result in equivalent groups, Exhibit 9-3 following this page presents p values for the significance of differences between program and control groups for each of 12 baseline characteristics in each of the 21 CCDP projects. The baseline characteristics are as follows:

- Child's sex: male/female;
- Child's age: age of focus child at recruitment (months);
- Mother's age: age of mother at birth of focus child (years);
- Primary language: English/other;
- Ethnicity: American Indian, Asian, African-American, Hispanic, or Caucasian;
- Marital status: mother married or living with partner/mother single, widowed, divorced, or separated;
- Mother's education: years of schooling completed;
- Father home: father in the home (yes/no);
- Subsidized housing: family lives in public or subsidized housing (yes/no);
- Own transportation: family has own transportation (yes/no);
- Household size: number of household members; and
- Per person income: household per person income.

Exhibit 9-3

The p Values for Baseline Differences Between Program and Control Group Families by Project (Full Evaluation Sample)

Project ID	Child's Sex	Child's Age	Mother's Age	Primary Language	Ethnicity	Marital Status	Mother's Education	Father in Home	Subsidized Housing	Own Transportation	Household Size	Per Person Income	No. With $p<0.05$	No. With $p<0.004$
01	0.089	0.149	0.540	0.282	0.046	0.042	0.138	0.901	0.677	0.112	0.482	0.966	2	0
02	.531	.469	.074	.335	.086	.472	.464	.653	.515	.425	.010	.017	2	0
03	.062	.779	.153	.150	.478	.091	.121	.024	.084	.115	.038	.968	2	0
05	.629	.471	.246	.625	.148	.525	.985	.272	.234	.823	.134	.780	0	0
06	.144	.647	.814	.340	.302	.565	.402	.330	.315	.418	.454	.228	0	0
07	.220	.741	.469	.408	.401	.635	.936	.479	.071	.120	.438	.704	0	0
08	.587	.914	.539	*	.446	.287	.179	.040	.014	.171	.865	.976	2	0
09	.303	.107	.490	.211	.033	.006	.318	.089	.012	.575	.187	.261	3	0
10	.448	.757	.894	.315	.999	.520	.369	.269	.007	.237	.535	.507	1	0
11	.437	.409	.027	*	.098	.321	.005	.401	.654	.089	.617	.880	2	0
12	.155	.905	.318	.784	.196	.339	.986	.477	.839	.002	.073	.044	2	1
13	.677	.053	.576	.454	.407	.405	.823	.402	.967	.058	.848	.347	0	0
14	.941	.063	.485	.297	.316	.844	.916	.298	.372	.965	.162	.099	0	0
15	.042	.527	.894	.967	.224	.311	.038	.069	.891	.521	.618	.952	2	0
16	.888	.740	.940	.333	.389	.247	.494	.035	.338	.151	.844	.465	1	0
17	.263	.018	.708	.204	.852	.281	.364	.097	.314	.274	.919	.357	1	0
18	.198	.920	.787	.081	.498	.754	.446	.262	.060	.535	.011	.701	1	0
19	.725	.595	.235	.260	.218	.309	.236	.333	.083	.020	.479	.654	1	0
20	.070	.889	.626	.452	.000	.121	.176	.298	.768	.198	.436	.339	1	1
21	.995	.371	.984	.682	.695	.114	.677	.469	.432	.113	.110	.974	0	0
22	.845	.678	.716	.271	.626	.316	.159	.680	.878	.114	.664	.123	0	0

* The p value could not be computed.

Note: Project ID's in this exhibit are not related to the project ID's used in exhibits in earlier chapters.

Exhibit 9-3 shows the results of a total of 12 * 21 = 252 statistical tests between program and control groups. Of the total tests, 23 were statistically significant at the $p<0.05$ level (compared with 0.05 * 252 = 13 expected by chance) and 2 were statistically significant at the $p<0.004$ level (compared to 0.004 * 252 = 1 expected by chance; use of this more stringent significance level which is calculated as 0.05 divided by 12 tests = 0.004 protects against spurious significant effects due to conducting so many statistical tests).

Using the liberal $p<0.05$ level, there were no CCDP projects with more than 3 of 12 significant statistical tests, and no baseline characteristics with more than 3 of 21 significant tests. Using the more conservative $p<0.004$ level, there were only two significant tests in total. These findings provide evidence that the randomization procedure produced statistically equivalent groups, at least as measured by these baseline variables. The fact that there are a few statistically significant differences between groups in some projects for some baseline characteristics suggest that it is important to include those baseline characteristics as covariates in the impact analyses.

Replacement Families

Replacement families serve two purposes in the CCDP projects. From the point of view of service provision, CCDP grantees use replacement families to replace program families that become inactive (through dropping out, moving, etc.) in order to maintain their service levels. This is very important because one would not want the concentration of resources to change over time in the CCDP sites. From the point of view of the impact evaluation, replacement families serve a very limited function. Replacement families were included in the evaluation sample only if (1) they were from a project that randomly had assigned families to one of three groups—a program, a control, or a replacement group; (2) they were selected randomly from the replacement group; and (3) they were used to fill vacancies in the program or control group that had occurred due to the following:

- The project had difficulty recruiting sufficient numbers of families to fill all the groups and was granted permission by ACYF to use their replacement families as "original" program or control families;

- The project lost families before the families were notified of their assignment (e.g., because the family had moved); or

- An originally assigned family was determined to be ineligible at the time of enrollment because of the family's income, the death of the focus child, or the age of the focus child.

The impact evaluation sample includes a total of approximately 150 program families and 150 control group families who were initially designated as replacements.

AREAS OF MEASUREMENT

The research questions call for obtaining the following types of information on individuals and families in both the program and in the control groups:

- Baseline demographic information on each family and on each focus child's birth status;
- Nature and quantity of the health, educational, and social services received by each focus child and mother during the period of the evaluation;
- Parent outcomes (i.e., physical, psychological, and economic status of each mother over the period of the evaluation and the use of government-subsidized services);
- Family outcomes (i.e., household stability, family resources, problems, and relationships over the period of the evaluation); and
- Child outcomes (i.e., the physical, cognitive, and social emotional status of each focus child over the period of the evaluation).

Measurement of Baseline Information

While the random assignment procedures discussed above were intended to ensure comparability of families, it is important to describe basic demographic characteristics of families in the evaluation across program groups. Most baseline data were collected on all families by CCDP project staff as part of the recruitment process. Thus, data from the projects' MIS provide most of the baseline information about families. Additional topics on which baseline data are being collected (through maternal recall interviews) include the focus child's birth status and the mother's reported use of drugs and alcohol during the pregnancy. Exhibit 9-4 following this page summarizes the baseline data collected and the sources of information.

Measurement of Services

The MIS provides detailed information on the services received by CCDP participants. These data are obtained from provider or project records rather than through the self-reported behavior of CCDP participants. The MIS covers the full range of services provided or brokered by CCDP, including maternal health care, child health care, adult education and training programs, and child care and early childhood education programs. However, the MIS contains no information on the services received by the control group, as it was designed to capture services received within the context of the CCDP projects. Hence, in spite of the richness of this data set, it cannot be used to examine the differences in services received by program and control families.

Exhibit 9-4

Measurement Plan for Baseline Information

Topic	Source
FAMILY DEMOGRAPHIC CHARACTERISTICS	
Child's age at recruitment	MIS
Race/ethnic group	MIS
Primary language	MIS
Marital status of mother	MIS
Father in home	MIS
Years of education of mother	MIS
Household size	MIS
Household annual income	MIS
Use of subsidized housing	MIS
Availability of own transportation	MIS
Mother's age	MIS
PREGNANCY/BIRTH OF FOCUS CHILD	
Weeks of pregnancy when first received prenatal care	Parent interview
Prematurity	Parent interview
Birth weight	Parent interview
Number problems/complications during pregnancy	Parent interview
Number of nights in special care	Parent interview
Mother's use of cigarettes, drugs, and alcohol during pregnancy	Parent interview

Valid controls between the program and control groups can only be made using the same measurement protocols, and so the impact evaluation has collected a limited set of self-reported information on services receipt for both groups. These data were collected through maternal self-reports on an annual basis as part of an in-person maternal interview.

Information on service receipt is collected for several major types of services, as seen in Exhibit 9-5 following the next page. For the focus child, the amount of services received is measured for child care/early childhood services and health services. For the mother and resident father/partner, the amount of services received is measured for case management, parenting classes, general education, job-related education, government assistance, substance abuse treatment, and other health services (both mental and physical).

Measurement of Parent Outcomes

CCDP is a family support program with anticipated effects for individual parents. The comprehensiveness of the CCDP services means that a wide array of effects is hypothesized. Therefore, the impact evaluation is assessing outcomes for parents in many areas, including the following:

- The mother's physical health status, including substance use;
- The mother's mental health/psychological status;
- The mother's parenting knowledge, attitudes, and practices; and
- The degree of economic dependency of the mother, resident father/partner, and the household as a whole, including education degrees, steps toward economic self-sufficiency, and employment and income.

In many of these outcome areas, standard measures do not exist, leading to the development and/or adaptation of survey items from other studies. Where existing measures were available, the goal was to select measures that (1) have been used in other large studies; (2) have been used with a variety of ethnic groups, including low-income parents and families; and (3) have adequate psychometric properties. Virtually none of the existing measures had been translated into Spanish or had been used extensively with Spanish-speaking populations. Therefore, the maternal interview for the CCDP evaluation was translated into Spanish. Exhibit 9-6 summarizes the measures, the data sources, and the data collection schedule for data collection on parent outcomes. All of the data on parent outcomes were collected in an in-person interview with the focus child's mother.

Measurement of Family Outcomes

In addition to effects on children and parents, CCDP is expected to influence family-level variables. For this evaluation, family outcomes are measured in the following areas: household stability, stability of the child's life, family problems, and quality of the home environment.

Exhibit 9-7 summarizes the measures, the data sources, and the data collection schedule for data collection on family outcomes. All of the data on family outcomes were collected in an in-person maternal interview.

Measurement of Child Outcomes

CCDP is expected to influence three aspects of children's development: physical health and growth, cognitive well-being, and social-emotional well-being. The following six criteria were applied when selecting measures: (1) the measure can be administered reliably by trained interviewers (because clinical assessments and observations by trained developmental psychologists are beyond the scope of this evaluation), (2) the measure is appropriate to the age of the children being tested, (3) the measure has been used extensively, (4) the measure reflects program goals, (5) the measure has adequate psychometric properties, and (6) the measure has been used with a variety of ethnic groups and with economically disadvantaged children.

In selecting measures, other evaluations of related programs for low-income children and families were reviewed. A priority was that the measures selected should, as much as possible, match measures being used or considered for use in other large-scale studies currently in place or being designed and implemented with similar populations. Recent research literature also was reviewed to identify less extensively used measures, and experts in the field were contacted.

Because a substantial number of Spanish-speaking families are being served by CCDP, the evaluation was particularly concerned with the appropriateness of measures for children in these families. Therefore, a number of researchers who currently are working in the area of testing children from various language groups were consulted. These experts were asked to help evaluate currently available standardized measures, identify any other standardized or nonstandardized measures, and suggest items that might be added to existing measures to address unique cultural issues for Spanish-speaking groups. In addition, comments were solicited from the staff at one of the CCDP projects that is working with Hispanic families. For this evaluation, child outcomes were measured in the following areas:

- Physical health, including immunizations, injuries, health problems, dental care, use of seatbelts, and overall health status; and

Exhibit 9-5

Measurement Plan for Receipt of Services

Service Area	Service Recipient(s)	Unit	Source
Case management/contact with social worker or caseworker	Mother	# contacts	Parent interview
Basic or general education classes	Mother, resident father/partner	# hours	Parent interview
Job-related training classes	Mother, resident father/partner	# hours	Parent interview
Life and parenting skills classes	Mother, resident father/partner	# hours	Parent interview
Drug, alcohol treatment program	Mother, resident father/partner	# visits	Parent interview
Mental health services	Mother, resident father/partner, focus child	# visits	Parent interview
Organized child care programs	focus child and preschool-age siblings	# months, # hours/day	Parent interview
Government benefits			
AFDC/public assistance received	Mother, household	# months	Parent interview
AFDC monthly benefit	Mother	$/month	Parent interview
Unemployment received	Mother, household	# months	Parent interview
Monthly unemployment benefit	Mother	$/month	Parent interview
Food Stamp benefits received	Mother, household	# months	Parent interview
Monthly Food Stamp benefit	Mother	$/month	Parent interview
Government job training	Mother, household	Any partic.	Parent interview
Veterans benefits	Mother, household	Any partic.	Parent interview
Social Security benefits	Mother, household	Any partic.	Parent interview
SSI benefits	Mother, household	Any partic.	Parent interview
WIC received	Mother, household	Any partic.	Parent interview
Food donations	Mother, household	Any partic.	Parent interview
Medicaid	Mother, household	Any partic.	Parent interview
Subsidized housing	Mother, household	Any partic.	Parent interview
Health care services			
Dental care	Mother, resident father/partner, focus child, siblings	# visits	Parent interview
Physical or occupational therapist	Mother, resident father/partner, focus child, siblings	# visits	Parent interview
Doctor's visit for acute illness	Mother, resident father/partner, focus child, siblings	# visits	Parent interview
Doctor's visit for chronic condition	Mother, resident father/partner, focus child, siblings	# visits	Parent interview
Preventive medical care	Mother, resident father/partner, focus child, siblings	# visits	Parent interview

Exhibit 9-6

Measurement Plan for Parent Outcomes

Topic	Measure	Source	Measurement Schedule
MATERNAL PHYSICAL HEALTH			
Overall health	Survey items*	Parent interview	Annually
Health habits	Survey items	Parent interview	Annually
Pregnancy-related health behavior	Survey items	Parent interview	Annually
MATERNAL MENTAL HEALTH			
Depression	CES-D	Parent self-rating	Annually
Locus of control	Pearlin and Schooler Mastery Scale	Parent self-rating	Annually
Positive outlook	Rand Subscales	Parent self-rating	Annually
Environmental stresses	NCAST Difficult Life Circumstances	Parent self-rating	Annually
PARENTING			
Attitudes linked to abusive behavior	Bavolek Adolescent-Adult Parenting Inventory	Parent self-rating	Annually
Expectations for child	Survey items	Parent interview	Annually
Mother/child interaction	Nursing Child Assessment Teaching Scale (NCATS)	Mother/child observation	Annually
Parent/child relationship	Survey items	Parent interview	Annually
MATERNAL ECONOMIC SELF-SUFFICIENCY			
Problemsolving strategies	Carver and Schrier COPE Subscales	Parent interview	Annually
Life skills	Survey items	Parent interview	Annually
Social connectedness	Survey items	Parent interview	Annually
Work-related attitudes	Survey items	Parent interview	Annually
EMPLOYMENT AND INCOME			
Education certificates, degrees	Survey items	Parent interview	Annually
Employment/salary	Survey items	Parent interview	Annually
Income	Survey items	Parent interview	Annually
Use of government assistance	Survey items	Parent interview	Annually

*Items adapted/taken from Abt surveys and other national surveys (e.g., NELS, Rand, RTI, CHS, and NIMH).

Exhibit 9-7

Measurement Plan for Family Outcomes

Topic	Measure	Source	Measurement Schedule
Household stability	Survey items[a]	Parent interview	Annually
Stability of child's life	Survey items	Parent interview	Annually
Family problems	NCAST Difficult Life Circumstances	Parent interview	Annually
Quality of home environment	HOME Scale	Parent interview	Annually

[a] Items adapted/taken from Abt surveys and other national surveys (e.g., NELS, Rand, RTI, CHS, and NIMH).

- Developmental effects, including cognitive and socioemotional development.

Exhibit 9-8 following the next page summarizes the measures, the data sources, and the data collection schedule for data collection on child outcomes. Much of the data were collected through a child status interview, which was administered to each child's mother.

DATA COLLECTION

An onsite team consisting of an onsite researcher (OSR) and a child tester (CT) was hired and trained to collect data in each site. All evaluation data were collected by one or the other member of the team. The CT was blind to the assignment of families to program and control groups, although ongoing contact with families may have eroded this desirable condition. Data collection for the impact evaluation began late in November 1991 and currently is scheduled to continue through September 1994. All data on children and families were collected through tests of children and in-person interviews with mothers.

For the most part, data collection takes place in the family's home. Each visit to the home for tests and interviews lasts 1½ to 3 hours, depending on the language used (Spanish-language interviews and tests take considerably longer) and the age of the child. The OSR's and CT's generally operate out of a home office or out of a small rental office and visit each family's home twice a year during the first 2 years of the focus child's life and annually thereafter.

Because the children were tested on or close to their birth dates, assessments and interviews were conducted throughout the year, rather than clustered at any particular annual time point. Testing was scheduled within a window of 1 month (i.e., 2 weeks before and after the birthday) when the child is younger than 36 months; at 36 months and thereafter, the window widens to 2 months.

The data collection process involved a variety of disparate elements. A core evaluation team selected, modified, and designed data collection instruments and developed training materials and procedures. This team also recruited, hired, trained, and monitored onsite data collection staff; provided information on the families and the testing schedule; planned and coordinated the flow of information to and from the sites; and prepared periodic reports on the progress of the data collection. The OSR's maintained the site office (either with an OSR's home or in a field office), contacted the mothers and scheduled interviews and tests, arranged transportation when necessary, conducted in-person interviews with the mothers, supervised the work of the CT's, maintained ongoing contact with the mothers and liaised with the CCDP projects, established and maintained a record system to document data collection, reviewed and cleaned data as well as transmitted data to be key-entered, and prepared regular reports on the progress of the data collection. Finally, the CT's administered standardized tests to the focus children, interviewed the mothers about their children's statuses, and reviewed and cleaned data before submitting the data to the OSR's.

The OSR's and CT's were recruited in spring 1991 and were trained to administer all of the major evaluation instruments including the maternal interview, the child status interview, and the Bayley Scales of Infant Development. Training also included an overview of the entire project, administrative procedures for organizing and maintaining site offices, as well as many other topics. In spring 1992 the field staff participated in a refresher training session, which included two new child assessment measures—the Kaufman-ABC (K-ABC) and the Peabody Picture Vocabulary Test (PPVT).

Training procedures were similar for the Bayley and the K-ABC. The field staff participated in a 2-day training session conducted by professional trainers and were required to conduct at least four practice administrations at their sites. To assess the reliability of the field staff's scoring of the tests, they were required to view and score two videotaped administrations of the tests, to compute basal and ceiling scores for each, and to submit the protocols for review. There, study staff computed each tester's agreement with the criterion scoring. To assess the uniformity and accuracy of test administration, the field staff were asked to provide videotapes of themselves administering the tests. These tapes were reviewed by an experienced tester. Each member of the field staff was judged as passing or failing on three indicators: (1) scoring the reliability tapes, (2) computing basal and ceiling scores for each child, and (3) administrating of the tests. Only a small number of staff required some retraining on correct administration. After the retraining, the field staff were required to make another videotape of their administration of the tests. For the PPVT, which is a much more straightforward measure, reliability was assessed at the end of the training session.

ANALYTIC APPROACH TO ASSESSING PROGRAM EFFECTS

As discussed previously, CCDP is expected to have positive effects on children, parents, and families in several different areas. But what is meant by a "positive effect"? For this study, the effect of CCDP on a group of participating families is defined as the difference between an observation taken after participation in the program and what would have been observed if the families had not been in the program. Since it is impossible to know how the participating families would have performed if they had not been part of the program, it is necessary to estimate what that performance would have been. Such an estimate is called a "no treatment expectation" and is best generated by measuring control group families that,

Exhibit 9-8

Measurement Plan for Child Outcomes

Topic	Measure	Source	Measurement Schedule
PHYSICAL HEALTH/GROWTH			
Overall child health	Survey items*	Parent interview	12, 18, 24, 30, 36, 48, (60)** months
Injuries/accidents	Survey items	Parent interview	12, 18, 24, 30, 36, 48, (60) months
Nights in hospital for injuries	Survey items	Parent interview	12, 18, 24, 30, 36, 48, (60) months
Health problems	Survey items	Parent interview	12, 18, 24, 30, 36, 48, (60) months
Learning problems	Survey items	Parent interview	12, 18, 24, 30, 36, 48, (60) months
Treatment for learning problems	Survey items	Parent interview	12, 18, 24, 30, 36, 48, (60) months
Dental care	Survey items	Parent interview	12, 18, 24, 30, 36, 48, (60) months
Seatbelt use	Survey items	Parent interview	12, 18, 24, 30, 36, 48, (60) months
Immunization history	Survey items	Parent interview	12, 18, 24, 30, 36, 48, (60) months
Health services	Survey items	Parent interview	12, 18, 24, 30, 36, 48, (60) months
Dental services	Survey items	Parent interview	12, 18, 24, 30, 36, 48, (60) months
Early childhood education/infant stimulation	Survey items	Parent interview	12, 18, 24, 30, 36, 48, (60) months
Nutritional status	Survey items	Parent interview	Currently being developed
Diet-related health problems	Survey items	Parent interview	Currently being developed
COGNITIVE DEVELOPMENT			
General cognitive ability	Bayley Scales (MDI) Kaufman-ABC	Direct assessment Direct assessment	12, 18, 24 months 36, 48, (60) months
Receptive language ability	PPVT-R/TVIP	Direct assessment	36, 48, (60) months
SOCIAL AND EMOTIONAL DEVELOPMENT			
Adaptive behavior	Scott and Hogan Adaptive Behavior Scale	Parent interview	24, 36, 48 months
Behavior problems	Achenbach Child Behavior Checklist	Parent interview	24, 36, 48, (60) months
Treatment of psychological problems	Survey items	Parent interview	All testing points

*Items adapted/taken from Abt surveys and other national surveys (e.g., NELS, Rand, RTI, CHS, and NIMH).

**Potential for measurement at 60 months.

through random assignment, are statistically comparable to the program families. Postprogram observations made on program families then are compared to the no-treatment expectation to yield a measure of program effect.

The Analytic Samples

The analyses presented in this report draw upon data collected through interviews with mothers and tests administered to children during 1992 and early 1993. Both types of data collection were conducted in the same session, scheduled to occur as close to each focus child's birthday as possible. This report analyzes data collected on CCDP focus children at 2 years of age and on their mothers after 2 years of CCDP program operations.

Exhibit 9-9 following the next page presents information about the sample sizes in the overall evaluation and in the analytic samples used for this report. Each site is represented by a row in the table, and a total across all sites also is shown. The columns titled "N Originally Assigned" show the number of families in each site that were part of the original random assignment. The total of 2,214 program families and 2,197 control families comprise the entire impact evaluation sample, and data collection is attempted on each of these 4,411 families at each scheduled measurement point.

The columns titled "Child Analytic Sample" and "Mother Analytic Sample" show the sample sizes for the analyses presented in this report. The analytic sample of 2,699 children (1,286 program children plus 1,413 control children) represents 61 percent of the total, while the analytic sample of 2,818 mothers (1,289 program mothers plus 1,529 control mothers) represents 64 percent of the total. These samples are incomplete because the start of data collection was delayed for 8 months until approval of the set of data collection instruments was received from the Office of Management and Budget (OMB). This delay meant that many children (705 or 16 percent of the sample) could not be measured because, by the time data collection started, they had passed their second birthdays.

It should be noted that a higher response rate was achieved with control group families (64 percent of 24-month-old children) than with program families (58 percent of 24-month-old children). This difference is at least partly attributable to the fact that the evaluation was allowed to offer an incentive payment of $100 per year to control group families but not to families in the program group. The rationale for this decision (made by OMB) was that program families were receiving services and should not require a monetary incentive to participate.

Exhibit 9-10 displays the disposition of the sample of children at the 24-month measurement point. It shows that of the 4,411 children in the evaluation, 16.0 percent (705 children) were unable to be measured at the 24-month measurement point because they had passed their second birthdays, 13.0 percent were in families that could not be located, and 8.7 percent were in families that refused to participate in the measurement activities. This leaves 62.3 percent who completed interviews and who are included in the analytic sample for this report. When calculated as a percentage of the children who were actually eligible to be measured (on the basis of their age), the response rate is 74.2 percent.

Finally, data were collected from 87.7 percent of the families who could be located.

It is important to understand that the 705 children who could not be measured because they had passed their second birthdays will be measured at 36 and 48 months of age. The reason they were not measured at 24 months of age is that the start of data collection was delayed by OMB. Thus, completion rates are expected to be higher at 36 and 48 months than at 24 months (as of August 1993, measurements of 36-month-old children were being made with a 77-percent response rate).

Comparability of Program and Control Groups in the Analytic Samples

An understanding of how the random assignment process was implemented and the analyses of baseline variables presented earlier, as seen in Exhibit 9-3, showed that the full program and control groups were comparable at the start of CCDP. However, the fact that only 62.3 percent of the sample was measured for this report (37.7 percent was not measured), and that there were somewhat different response rates for program and control groups, raises the question of whether the program and control groups in the analytic sample remain comparable.

As noted above, a large percentage of the unmeasured families was missed because the start of data collection was delayed and the focus children passed their second birthdays. While this loss of data is unfortunate, it should not lead to any program/control group bias since birth dates should be randomly distributed across program and control groups.

Exhibit 9-11 contains the results of a series of analyses (identical to those shown in Exhibit 9-3) comparing program and control groups in each CCDP project on each of the same 12 baseline variables used in the analyses for the full evaluation sample. The children and mothers entering into these analyses are those included in the analytic sample, rather than the full evaluation sample, which was the subject of Exhibit 9-3.

The results are much the same as the results seen for the analyses of the full evaluation sample: There are very few statistically significant differences between groups in any project. The conclusion to be drawn is that the program and control groups in the analytic sample are, on the whole, statistically equivalent in terms of the 12 baseline variables. Of course, it is always possible that the groups vary on other unmeasured

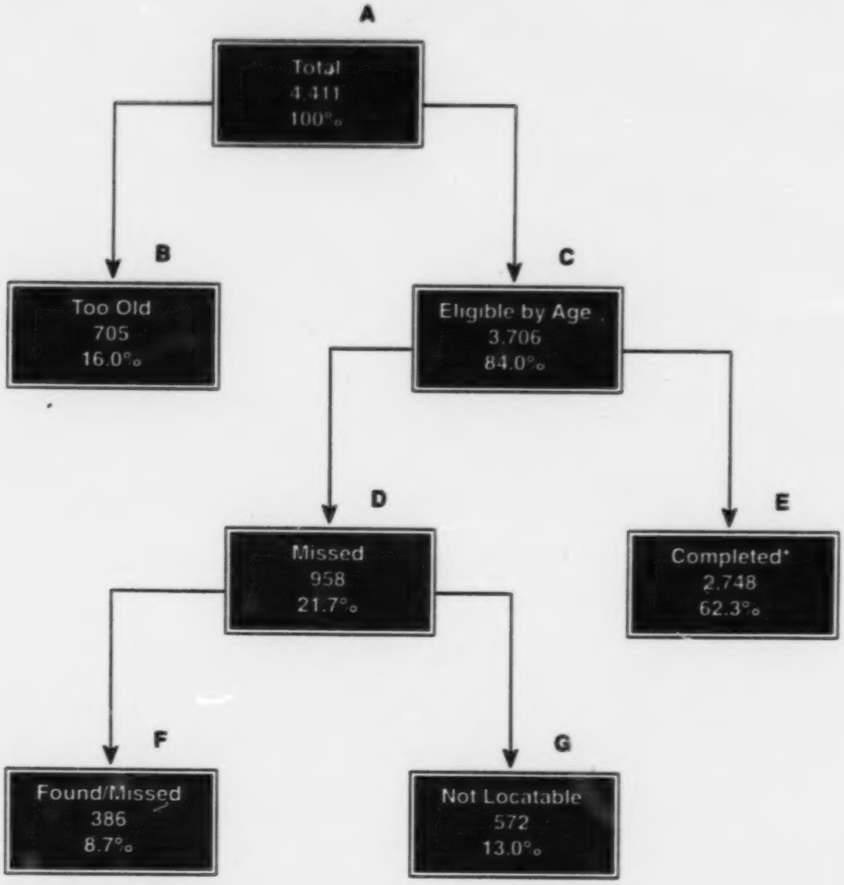
Exhibit 9-9

Sample Sizes in the CCDP Impact Evaluation

Site	Program			Control			
	N Originally Assigned	Child Analytic Sample	Mother Analytic Sample	N Originally Assigned	Child Analytic Sample	Mother Analytic Sample	Total
1	122	77	90	116	83	100	238
2	62	38	43	60	46	44	122
3	105	32	33	111	50	76	216
4	121	59	46	115	84	72	236
5	121	54	53	120	52	58	241
6	120	66	62	120	67	83	240
7	44	27	32	46	22	27	90
8	120	60	60	117	76	89	237
9	60	49	57	60	53	58	120
10	120	97	80	120	90	85	240
11	119	73	49	118	61	55	237
12	120	73	65	119	74	61	239
13	120	61	48	120	64	76	240
14	117	50	59	119	67	82	236
15	98	61	75	98	72	91	196
16	115	85	90	118	80	79	233
17	120	66	94	120	90	110	240
18	61	36	41	58	42	48	119
19	113	65	63	107	75	74	220
20	116	69	72	115	69	72	231
21	120	88	77	120	96	89	240
TOTAL							
(n)	2,214	1,286	1,289	2,197	1,413	1,529	4,411
(%)	100%	58%	58%	100%	64%	70%	

Exhibit 9-10

Summary of CCDP Data Collection for 2-Year-Olds


A
Total
4,411
100%
B
Too Old
705
16.0%
C
Eligible by Age
3,706
84.0%
D
Missed
958
21.7%
E
Completed*
2,748
62.3%
F
Found/Missed
386
8.7%
G
Not Locatable
572
13.0%

*Of the 2,748 completed cases, 49 were received too late to be included in the analyses conducted for this report, leaving a child-level analytic sample of 2,699 cases.

Exhibit 9-11
The p Values for Baseline Differences Between Program and Control Group Families by Project (Analytic Sample)

Project ID	Child's Sex	Child's Age	Mother's Age	Primary Language	Ethnicity	Marital Status	Mother's Education	Father in Home	Subsidized Housing	Own Transportation	Household Size	Per Person Income	No. With $p<0.05$	No. With $p<0.004$
01	0.114	0.415	0.897	0.150	0.004	0.068	0.187	0.826	0.707	0.163	0.332	0.590	1	1
02	.387	.878	.149	.557	.175	.383	.320	.825	.746	.251	.075	.061	0	0
03	.011	.570	.241	.268	.831	.716	.146	.180	.014	.344	.314	.701	2	0
05	.201	.288	.087	.196	*	.647	.657	.307	.994	.610	.645	.649	0	0
06	.105	.665	.549	.293	.319	.418	.706	.526	.535	.810	.272	.751	0	0
07	.194	.593	.367	.130	.170	.679	.430	.569	.375	.068	.440	.668	0	0
08	.025	.433	.704	*	.327	.066	.322	.012	.300	.453	.812	.972	2	0
09	.080	.655	.454	.178	.001	.026	.330	.535	.040	.849	.488	.557	3	1
10	.296	.913	.714	.311	.743	.717	.256	.225	.008	.137	.251	.319	1	0
11	.147	.622	.030	*	.525	.890	.018	.864	.678	.052	.201	.521	2	0
12	.133	.633	.790	.449	.427	.338	.725	.669	.549	.317	.644	.626	0	0
13	.576	.091	.640	.010	.382	.481	.744	.812	.935	.999	.282	.080	1	0
14	.842	.814	.605	.429	*	.401	.430	.169	.345	.542	.365	.285	0	0
15	.008	.208	.726	.461	.426	.312	.038	.026	.530	.710	.072	.411	3	0
16	.912	.707	.822	.206	.093	.109	.698	.031	.310	.119	.801	.443	1	0
17	.656	.008	.590	.266	.602	.152	.815	.177	.266	.976	.556	.219	1	0
18	.208	.913	.922	.275	.653	.476	.509	.977	.191	.727	.002	.274	1	1
19	.829	.953	.140	.547	.145	.819	.375	.771	.031	.058	.284	.680	1	0
20	.124	.511	.291	.900	.000	.286	.467	.742	.693	.148	.887	.196	1	1
21	.595	.185	.850	.636	.953	.784	.764	.550	.572	.068	.328	.823	0	0
22	.624	.464	.794	.284	.698	.302	.425	.515	.995	.091	.811	.308	1	0

*The p value could not be computed.

Note: Project ID's in this exhibit are not related to the project ID's used in exhibits in earlier chapters.

variables, but the analyses conducted here are encouraging and give us a reasonable amount of confidence in attributing observed differences between program and control groups to CCDP rather than to other factors.

Decoupling the Mother and Child Analytic Samples

The mother and child analytic samples were decoupled due to the wide variation in the dates when families were enrolled into CCDP. Some families were enrolled as early as January 1990, while other families were not enrolled until March 1991. Therefore, two families whose children were tested at approximately the same calendar date could have differed by as much as 15 months in their enrollment dates. Furthermore, at the time of enrollment, focus children were allowed to be as old as 12 months or as young as 6 months (in cases in which the mother recently found out she was pregnant). Thus, the mother's outcomes measured on the focus child's second birthday could reflect quite disparate lengths of service in CCDP. The present strategy allowed child outcomes to be age linked, while mothers with roughly the same length of service in CCDP were compared. This is an important distinction to keep in mind while reading this report.

Effects on children are measured at a given point in time, when children reach age 2. Because there was variation in the ages of the children at the time of enrollment in the program, there also is variation in the amount of exposure to CCDP at each birthday. Children develop rapidly at these early ages; therefore, measurements were linked to birthdays rather than set calendar dates. On the other hand, effects on mothers are more appropriately measured at a set point in time, since time in the program is a key for producing parent outcomes. For reasons of cost-efficiency, children and mothers were measured at the same interview point, but because there are multiple measurement points, the child and parent measures were decoupled. For the purposes of this analytic report, mothers were included in the analytic sample as long as they had participated in CCDP for 2 years or less. This explains why the mother analytic sample is larger than the child analytic sample: In addition to being measured at their children's second birthdays, mothers included in this analytic sample could have been measured when their children were anywhere from 12 to 36 months of age.

Estimating the Overall Effect by Combining Results Across Sites

The analyses conducted for this report and presented in subsequent chapters are ones which address questions about the overall effectiveness of CCDP, that is, questions which do not distinguish among the effects of individual CCDP projects. The reason for this approach is that the CCDP demonstration has been implemented as a test of a particular family support model. There has been no emphasis in the demonstration on building in systematic variation in how different CCDP projects are implemented. To the contrary, each project is required to adhere to performance standards and to have common sets of services. Furthermore, CCDP projects were told that the primary purpose of the evaluation was to test the overall CCDP model and, therefore, to seek overall effects rather than to determine whether some projects were more effective than others, or to determine which project was most effective.

Therefore, the research questions for this evaluation are ones which ask about the overall effects of CCDP, rather than ones which seek to compare the effects of different projects, and one of the analytic challenges facing the evaluation was how to combine data which were collected from multiple sites. One option, which was rejected, is to pool data from the 21 sites into a single large analysis, and compare the overall mean outcome values for all program and control group families. Because random assignment of families to program or control groups took place at the individual site level, not at the level of all 21 sites combined, pooling the data into one large analysis is inappropriate in that it departs from the way in which families were assigned to groups. Furthermore, this approach would have been inefficient because the variance of the estimated combined impact would have been inflated due to the differences among site means (Fleiss, 1986). Therefore, the overall program impact on any given measure has been estimated by computing separate site-level impact estimates and then averaging those estimates.

Statistical Model

Program impacts were estimated for many outcome variables measured on children, mothers, and families. This was done for each of the 21 CCDP projects participating in the evaluation by comparing the average values of a given outcome variable for CCDP families with the average values for that outcome variable for control group families. Even though the random assignment of families to program or control groups ensures that the two groups include comparable families, statistical controls were used to compensate for any initial differences between the groups that occurred by chance in order to (1) increase the precision of the estimates and (2) adjust for the potential biasing effects of attrition. After calculating the effect of CCDP in each participating site, the individual site-level impact estimates were combined to yield the overall effect of CCDP for each outcome measure.

Details on the Statistical Model

For each given outcome variable, program impacts were estimated using a two-stage estimation strategy. In the first stage, each outcome variable was modeled using ordinary least squares regression based on all cases in the evaluation (n = 2,699 children and 2,818 mothers) with a total of 62 parameters: an intercept, 20 baseline covariates, 20 site-level variables, and 21 site-by-treatment interaction variables. The stored residuals from this analysis were squared and averaged by site to produce a mean squared error for each of the 21 sites. These mean squared residual terms formed the basis of weights used in the second stage of the analysis. In the second stage, a correction was made for heteroscedasticity of variance among sites by weighting each observation by an inverse of the adjusted mean square error. The adjustment consisted of multiplying the mean square error for a site by (n/[n-1]), where n was the sample size for that site. This procedure produced more accurate estimates of the standard errors than ordinary least squares.

Finally, in order to produce an overall estimate of impact on a given outcome variable, the 21 site-level effect estimates were averaged. The estimated average effect then was divided by the square root of the pooled variance across the 21 sites to produce a t statistic, which was used in a one-tailed test with 62 degrees of freedom. Statistically significant results are reported for p values of less than 0.10. One-tailed significance tests were employed, since CCDP is expected to produce differences favoring the program group.

Such a liberal approach to judging program effects was adopted at this early stage in the evaluation where we wish to be careful not to eliminate promising lines of future analysis. The final report from this evaluation will likely adopt a more conservative approach to assessing program effects.

Covariates Used in the Model

As stated above, the multivariate regression model used in the CCDP impact analysis included a set of 20 covariates representing participant characteristics at baseline. The same covariates were used in all outcome analyses, regardless of which outcome variable was being assessed and regardless of whether the variable was measured on the child, parent, or family. The set of covariates includes 12 baseline variables based on data collected when families were recruited and enrolled into CCDP, as well as 8 risk factors connected with the birth of the focus child.

The 12 baseline variables included in the set of covariates are as follows:

- Age of focus child at recruitment (continuous);
- Teen mother at birth of focus child (yes/no);
- Family's primary language is English (yes/no);
- Family's ethnicity is African-American (yes/no);
- Family's ethnicity is Hispanic (yes/no);
- Mother is married or living with partner (yes/no);
- Mother's years of education (continuous);
- Father is at home (yes/no);
- Family lives in public/subsidized housing (yes/no);
- Family has own transportation (yes/no);
- Number of household members (continuous); and
- Total annual household income per person (continuous).

The eight risk factors included in the set of covariates are as follows:

- Number of months that the mother was pregnant with the focus child when she first saw a doctor;
- Number of weeks that the focus child was premature;
- Number of problems during pregnancy;
- Number of nights that the focus child spent in a hospital's special care unit;
- Focus child's birth weight (grams);
- Number of cigarettes that the mother smoked per day while pregnant with focus child;
- Frequency of alcohol use by mother while pregnant with the focus child; and
- Mother used drugs while pregnant with the focus child (yes/no).

Descriptive statistics on each of the covariates are presented later in this report.

There is no theoretical justification for assuming differential effects of the covariates across CCDP sites; therefore, the covariates were included in the impact model to help adjust for any differential attrition in the analysis sample and to increase the precision of the impact estimates, thereby allowing higher levels of statistical power. No attempt has been made to interpret the coefficients of the covariates. The aim in including them was simply to obtain the most accurate possible estimates of the overall effect of CCDP.

There are alternative modeling strategies that allow for random variation of covariates across sites. These multilevel modeling analytic procedures (e.g., hierarchical linear modeling) attempt to explain this variation as a function of site-level factors. With only 21 sites, there is limited power to detect and explain any intersite differences in the impact of CCDP. To the extent that reliable site-level data on program characteristics become available, other analytic strategies will continue to be explored, such as hierarchical linear modeling, to address the question of why impacts vary across sites.

Because the covariate set was used in all outcome analyses, it was important to have complete data on all covariates for all families. However, data were missing for some families for each covariate. Over 60 percent of the families in the evaluation sample had complete data on all 20 covariates. Eleven families who were missing data for all covariates were eliminated from all future analyses. Missing covariate data were estimated for all other families by means of a multiple regression imputation method. Patterns of valid and missing responses were computed for each case in the evaluation sample. A series of multiple regression analyses were conducted on families which had data for a given set of variables. The regression coefficients estimated from these analyses then were used to impute missing values for a given outcome variable by site. Exhibit 9-12 following the next page shows the extent of missing data for each covariate prior to conducting the imputation. Some covariates were present for almost all families, while other covariates were missing for over 20 percent of the families in the evaluation sample. After carrying out the imputations, a complete set of data was available for the 20 baseline covariates on 2,818 mothers and 2,699 children. Imputing data reduces the amount of variation in the covariates being estimated, somewhat reducing the effectiveness of the covariates relative to a data set containing complete data for all cases. However, the alternative is to omit cases with missing covariate data from the analysis, an unacceptable choice that would reduce the size of the data set by 40 percent.

Displaying Results

In Chapters 10 and 11, the results of the impact analyses are displayed in bar chart form. Where possible, variables are grouped by outcome area (e.g., parent health outcomes) and are displayed in a single exhibit. For each variable, either one bar is displayed, indicating the control group mean (if the analysis shows no significant effect of CCDP), or two bars are displayed, indicating the control group mean as well as the weighted, covariate-adjusted CCDP mean (if the analysis shows that there is a significant effect). Thus, if an exhibit shows that the control group mean for a given variable is 15 percent and the CCDP mean is 20 percent, the 5-percentage point difference represents the weighted, covariate-adjusted effect of CCDP.

BASELINE CHARACTERISTICS OF THE IMPACT EVALUATION SAMPLE

A detailed description of the baseline characteristics of families participating in the CCDP national impact evaluation is contained in Appendix D of this report. Some key characteristics of the sample are listed below:

- Forty-two percent of the children in the sample are African-American, 27 percent are Hispanic, 26 percent are white, 3 percent are American Indian, and 1 percent are Asian/Pacific Islander.

- Eighty-four percent of the children in the sample use English as their primary language, 14 percent use Spanish, and 2 percent use some other primary language.

- Twenty-five percent of the mothers in the sample were teenagers when they were recruited into CCDP.
- Fifty-two percent of the mothers in the sample had not graduated from high school at the time of recruitment into CCDP.
- Fifty-eight percent of the mothers in the sample were single and living without a partner at the time of recruitment into CCDP.
- Forty-four percent of the households in the sample had a total income under $5,000 and 85 percent had a total income under $10,000 at the time of recruitment into CCDP.

One of CCDP's objectives is to provide research evidence about ways to improve Head Start. Hence, it is important to determine the extent to which CCDP and Head Start families represent the same population. An analysis of selected characteristics of CCDP and Head Start families, as seen in Exhibit 9-13 following this page, shows that the two groups are quite comparable in terms of household income, racial/ethnic composition, and primary language. The data show that CCDP families have a slightly lower income and are somewhat more likely to be Hispanic or African-American than Head Start families. But these differences are not large.

SUBGROUP ANALYSES

In addition to overall comparisons of program versus control group families, additional analyses were conducted in order to determine whether CCDP projects are differentially effective with certain important subgroups of participants. Analyses were conducted on subgroups defined by the following variables:

- Teen mother at birth of focus child (yes/no);
- Mother's education level at time of entry into CCDP (high school graduate/not high school graduate);
- Mother's marital status at time of entry into CCDP (married or living with partner/not married or living with partner); and
- Gender of focus child (male/female).

These variables were seen as being policy relevant, and in addition, there was a reasonable distribution of the sample across subgroups within each CCDP project. Other potential grouping variables—such as race/ethnicity, primary language, and household size—were excluded from the subgroup analyses because of poor distributions or limited policy relevance.

Exhibit 9-12

Percentage of the Evaluation Sample With Missing Data on Covariates

Covariate	Percentage of Families With Missing Data
African-American race/ethnicity	1.3%
Hispanic race/ethnicity	1.3%
Teenage mother	13.6%
Public/subsidized housing	7.4%
Family has own transportation	7.4%
Mother married or living with partner	8.9%
Primary language is English	7.4%
Father present in the home	2.5%
Mother's education (in years)	14.6%
Number of household members	2.5%
Child's age at recruitment	5.8%
Household income per person	7.5%
Number of pregnancy problems	20.6%
Use of alcohol during pregnancy	21.1%
Child's birth weight	21.3%
Months pregnant when mother first saw doctor	21.2%
Number of weeks child was premature	20.9%
Number of nights child was in special care unit	21.3%
Number of cigarettes smoked during pregnancy	21.2%
Use of drugs while pregnant	21.3%

Exhibit 9-13

Comparison of CCDP and Head Start Family Characteristics

Family Characteristic	CCDP	Head Start
Household Income		
Less than $3,000	16.3%	16.2%
$3,000 - $5,999	38.4%	31.6%
$6,000 - $8,999	24.4%	25.4%
$9,000 - $11,999	13.3%	17.0%
$12,000 or more	7.6%	9.9%
Race/Ethnicity		
American Indian	2.7%	3.9%
Asian/Pacific Islander	1.4%	3.2%
Hispanic	27.3%	21.5%
African-American	42.2%	36.8%
Caucasian	26.4%	34.6%
Dominant Language		
English	83.6%	81.1%
Spanish	14.2%	15.1%
Other	2.2%	3.8%

The analytic approach for the subgroup analyses mirrored the analysis for the full sample. For example, the sample was divided into teen mothers versus nonteen mothers and estimated impacts separately for the two subgroups. The two estimated impacts then were compared to determine whether they differed significantly.

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Chapter 10. DIFFERENCES IN SERVICES UTILIZATION FOR FAMILIES IN THE IMPACT EVALUATION

This chapter describes the differences in services utilization by Comprehensive Child Development Program (CCDP) families and control group families participating in the impact evaluation. An increase in use of services on the part of families in CCDP compared with families in the control group will provide evidence that the program has been implemented and that it is effective in increasing levels of services utilization over time. Achieving this key link in the causal chain of events presumed to stem from CCDP will enhance our ability to argue that subsequent short- or long-term effects are due to CCDP rather than to other factors. If, on the other hand, there is no evidence that services utilization is increased for CCDP families, then the prospects are dimmed for achieving either short- or long-term effects on parents, children, and families.

The findings presented in this chapter are based on analyses of data collected from families included in the sample for the CCDP impact evaluation. Because about one-third of all families originally assigned to CCDP have dropped out or have been terminated from the program and are no longer receiving services from the CCDP program, the evaluation sample includes some families that participated for only a few days or weeks, other families that participated for several months and then were terminated, and still other families (the majority) that have participated from the start of the program through the time that they were interviewed and tested as part of this evaluation. Thus, service utilization questions were asked of some families who had not been receiving services from CCDP for several months. All of these families were randomly assigned to CCDP or to the control group, and the strength of the evaluation design rests on preserving that random assignment. Excluding the terminated families from the evaluation analysis would destroy the evaluation design.

The implication of the decision to include all terminated families in the impact evaluation is that statistics about participation in social, educational, and health services are likely to be lower than would be the case if all families were participating fully in the program. Thus, the most important aspects of the services utilization data presented in this chapter are the size and significance of the differences between program and comparison groups on each service variable—not the absolute percentages of program families that use each service.

SUMMARY OF DIFFERENCES IN SERVICES UTILIZATION

The following are summaries of key findings on differences in services utilization for both CCDP and control group families.

- *Case management services.*—CCDP relies on case management as a key to services provision. Hence, it makes sense that CCDP families were more than three times as likely as control families to have seen a social worker[1] and that they met with a social worker 14 times as often in 1 year as control families. These are very large differences and ones which would be expected, given the level of resources that CCDP is expending on case management services and the importance of case management to the CCDP model.

- *Physical health services for mothers.*—In terms of the health of CCDP mothers, no changes were detected on the frequency of physical checkups or of dental care and no change on receipt of substance abuse services. While there was no change on doctor's visits for acute health care, CCDP mothers were seen more often for care for chronic illnesses.

- *Mental health services for mothers.*—Mothers in CCDP were more likely to use mental health services than control group mothers, as were their partners. This may be an indication that CCDP has increased the salience of mental health, has made mothers more aware of the range of counseling services available to them, and has facilitated their access to such services.

- *Parenting services.*—CCDP mothers were more likely than control mothers to have participated in parenting classes.

- *Economic self-sufficiency services.*—Large changes were found on the use of services designed to facilitate economic self-sufficiency. CCDP mothers were more likely than control group mothers to have been enrolled in academic classes and vocational/job training classes and were more likely to be working toward a trade certificate, a GED (general equivalency diploma), or a bachelor's degree. There were similar though smaller changes for the partners of CCDP mothers.

- *Physical health services for children.*—Mothers reported that a significantly greater percentage of CCDP children than control group children had been to a doctor for a checkup during the past year (87 percent versus 84 percent). However, there was no difference in the percentage of children who had been seen by a doctor for an acute condition (66 percent), for a chronic condition (7 percent), or for any other problem (7 percent). Finally, according to the mothers, there were no program/control group differences in the proportion of children who visited the dentist at least once in the past year.

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[1] The difference between the percentage of CCDP families in the impact evaluation who reported using case management and the percentage of CCDP families in the process study who used case management may be explained by several factors. First, the process study sample included only currently active families, virtually all of whom were receiving case management services, whereas the impact study sample included many families who had left the program. Second, process study data were contemporaneous records made by program staff, whereas impact study data were parent reports, based on recall over a 1-year period. Parents may have failed to recall some meetings with their case managers or may not have defined some contacts as "meetings."

- *Development services for children.*—CCDP has had large, positive effects on the receipt of services designed to affect children's development. The learning problems of CCDP children were more likely to be diagnosed than those of control group children (assuming that children in the two groups were equally likely to have such problems). CCDP children also were more likely than children in the control group to have been participating in organized early childhood programs, both those which were designed to provide assistance to working mothers or to mothers in school as well as programs which were not related to the mothers' work or schooling.

The remainder of the chapter discusses in depth the changes that occurred in services utilization for families in the impact evaluation and outlines the differences between the program and control groups for each of the aforementioned services.

CASE MANAGEMENT SERVICES

Case management is a primary ingredient in all CCDP projects. According to Hubbell et al. (1991), CCDP service delivery relies on family-focused case management, and all but one CCDP project uses a model in which each family is assigned a case manager who coordinates all activities. While the titles (e.g., case manager, caseworker, social worker, family worker, or family advocate) and the exact functions of the case managers vary from project to project, all projects conduct a family needs assessment and prepare a family service plan. Among other functions, case managers make frequent home visits, help deal with family crises, and provide child development training.

Data from the maternal interview, summarized in Exhibit 10-1 following the next page, show that CCDP mothers were more likely than control group mothers to have met with a social worker (58 percent versus 18 percent). CCDP mothers met with social workers an average of more than once per month as opposed to control group mothers, who met with social workers an average of about once per year. When asked about several different types of services that could be received from social workers, CCDP mothers were more likely than control group mothers to say that they met with a social worker to set goals for themselves or their children (49 percent versus 9 percent); to talk about how to improve life for themselves or their families (49 percent versus 11 percent); to get ideas about how to organize daily life (34 percent versus 5 percent); and to get advice on taking better care of children (39 percent versus 6 percent), on grocery shopping for better and more nutritious foods (19 percent versus 2 percent), on how to get medical care for themselves and their children (29 percent versus 5 percent), and on how to receive government benefits (22 percent versus 4 percent).

All of these differences are large, which would be expected given the level of resources that CCDP is expending on case management services and the importance of case management to the CCDP model. In fact, one might wonder why "only" 58 percent of the CCDP mothers reported that they met with a social worker, when it seems that all CCDP families should have received this service. One reason why this could have occurred is that approximately one-third of the families originally assigned to CCDP were, for one reason or another, terminated from the program by the time that they were contacted for data collection. A few of these families may never have received any program services, others may have taken part for only a few weeks or months, and others may have participated for up to 2 years. Because the parent interview asked about case management services received during the past year, it is possible that a substantial proportion of the 42 percent of mothers who did not recall any social work services during the past year were correct and that they simply had terminated from the program 1 year or more ago. Other reasons for the relatively low percentage of mothers recalling receipt of social work services could include faulty recall on the part of the mothers or a true lack of service delivery on the part of CCDP.

PHYSICAL HEALTH SERVICES FOR MOTHERS

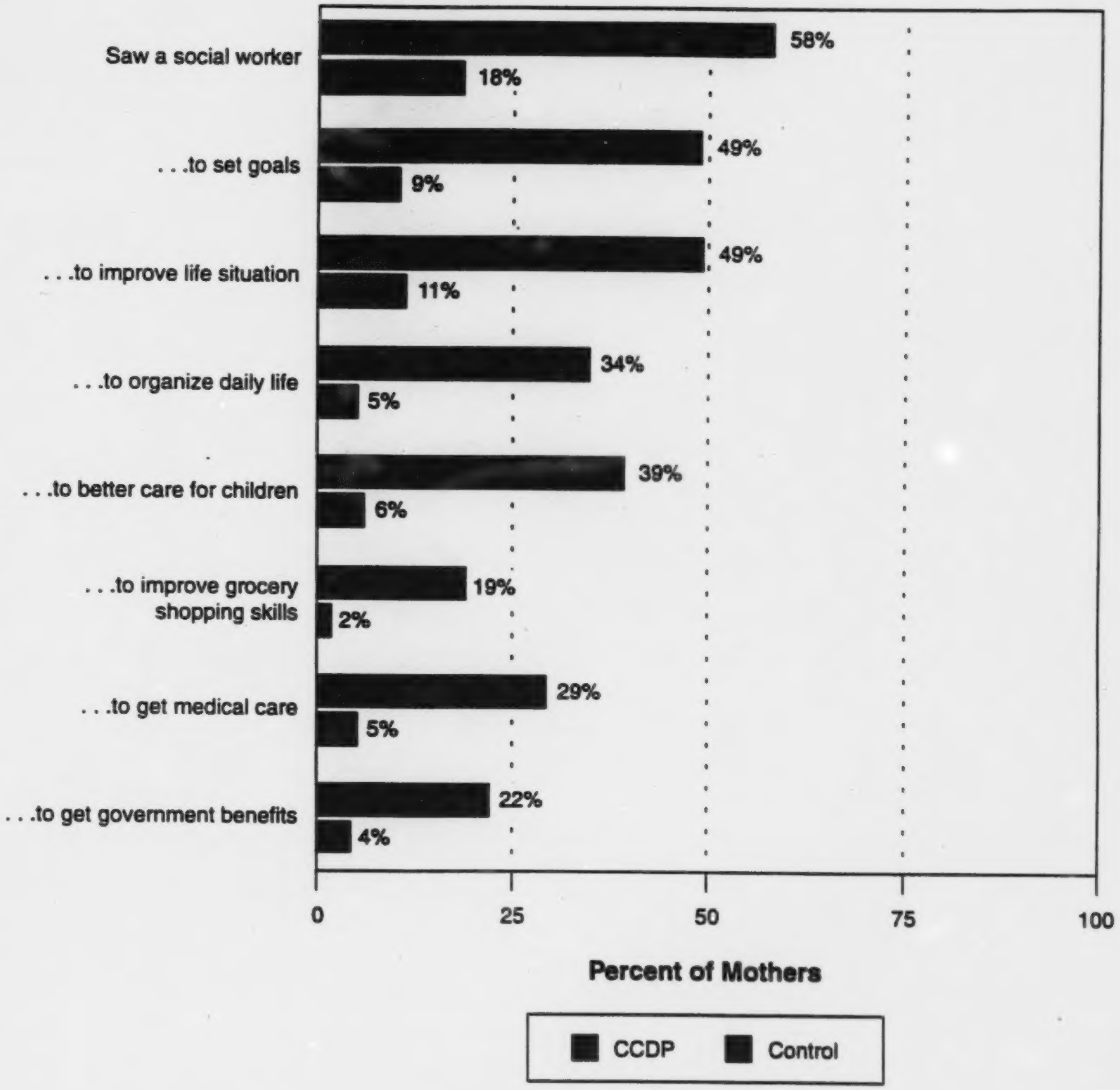
CCDP projects try to ensure that family members receive needed health care services with the hope that these services will result in the improved health of the family members. The mothers' physical health also may improve as an indirect consequence of improved psychological well-being or improvement in economic status. However, it is unclear how long it takes to achieve such improvements, and major changes in health status are not expected at this point in the evaluation (mothers have participated for only 1 or 2 years). More substantial changes may be expected at the end of the program, when many mothers in the evaluation sample will have had additional years of service.

As part of the maternal interview, mothers were asked to report on the nature and frequency of health services that they received during the previous year. These included mental health services and physical health services (e.g., general health, dental, alcohol and substance abuse, and prenatal care). Findings are noted in Exhibit 10-2 following this page.

The mothers were asked a series of questions about the services they received from doctors during the past year. Sixty-six percent of all mothers

Exhibit 10-1

Summary of Effects on Mothers' Receipt of Case Management Services*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

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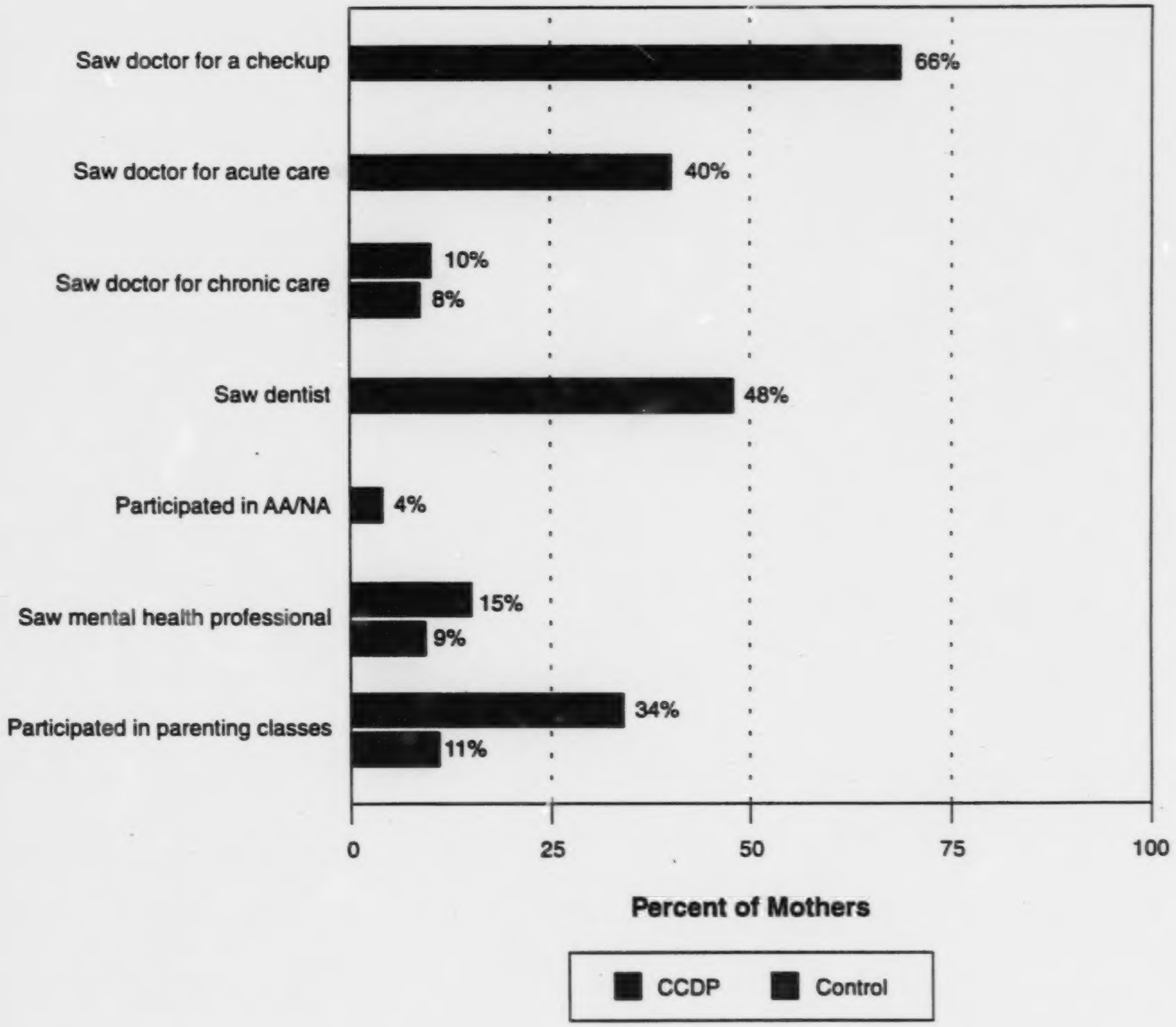
Exhibit 10-2

Summary of Effects on Mothers' Receipt of Health, Mental Health, and Parenting Services*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

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in the evaluation had visited a doctor for a checkup, with no difference between CCDP and control group mothers. Although there was no program effect with respect to the percentage of mothers that had visited the doctor for an acute condition (e.g., injuries or accidents), CCDP mothers were more likely than control group mothers (10 percent versus 8 percent) to have visited a doctor for treatment of a chronic condition (e.g., arthritis and hypertension).

The mothers were asked whether they had visited the dentist in the past year. Forty-eight percent indicated that they had done so, with no difference between CCDP and control group mothers.

The mothers also were asked whether they or their partners had participated in Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings and whether they or their partners had received any professional help for a drug or alcohol problem. Four percent responded that they had participated in AA or NA meetings, and 4 percent indicated that their partners had participated in such meetings, with no CCDP/control group difference in either case. Two percent of the mothers responded that they or their partners had received some professional help for substance abuse problems, again with no evident effect of CCDP.

MENTAL HEALTH SERVICES FOR MOTHERS

Maternal mental health is a major concern of CCDP, both because poor mental health may inhibit a mother's ability and willingness to pursue her own goals and because it often is associated with impaired parenting and with negative emotional and behavioral child outcomes. A number of the services offered by CCDP focus on supporting mothers' psychological well-being.

The maternal interview asked mothers to report whether they or their partners had received any treatment from a professional for any emotional, personal, or mental problem during the past year. Exhibit 10-2 shows that, on average, 15 percent of CCDP mothers had received mental health services compared to 9 percent of control group mothers. In addition, 7 percent of the partners of CCDP mothers had received mental health services compared to 6 percent of partners of control group mothers. This can be interpreted as an indication that CCDP may have increased the salience of mental health, made the mothers more aware of the range of counseling services available to them, and facilitated the mothers' access to such services.

PARENTING SERVICES

Virtually all of the CCDP projects provide services that are aimed at improving parents' knowledge about child development and appropriate parenting practices and at enhancing parents' self-confidence about their parental role.

Receipt of parenting services was measured as part of the maternal interview by asking mothers to report on the nature and frequency of participation in parenting education classes. Based on their self-reports, as seen in Exhibit 10-2, CCDP mothers were more likely than control group mothers to have participated in parenting classes (34 percent versus 11 percent) and to have spent more time in parenting classes (1.3 hours per month versus 0.3 hours per month). In addition, the live-in partners of CCDP mothers were more likely than their control group counterparts to have spent time in parenting classes. These findings show that CCDP has been successful at engaging mothers in activities that are designed to lead to improved parenting behaviors.

ECONOMIC SELF-SUFFICIENCY SERVICES

One of the major goals of CCDP is for parents to make progress toward greater economic self-sufficiency. Many CCDP services (e.g., job training, literacy training, and job counseling) focus directly on helping to improve the parents' educational and economic prospects.

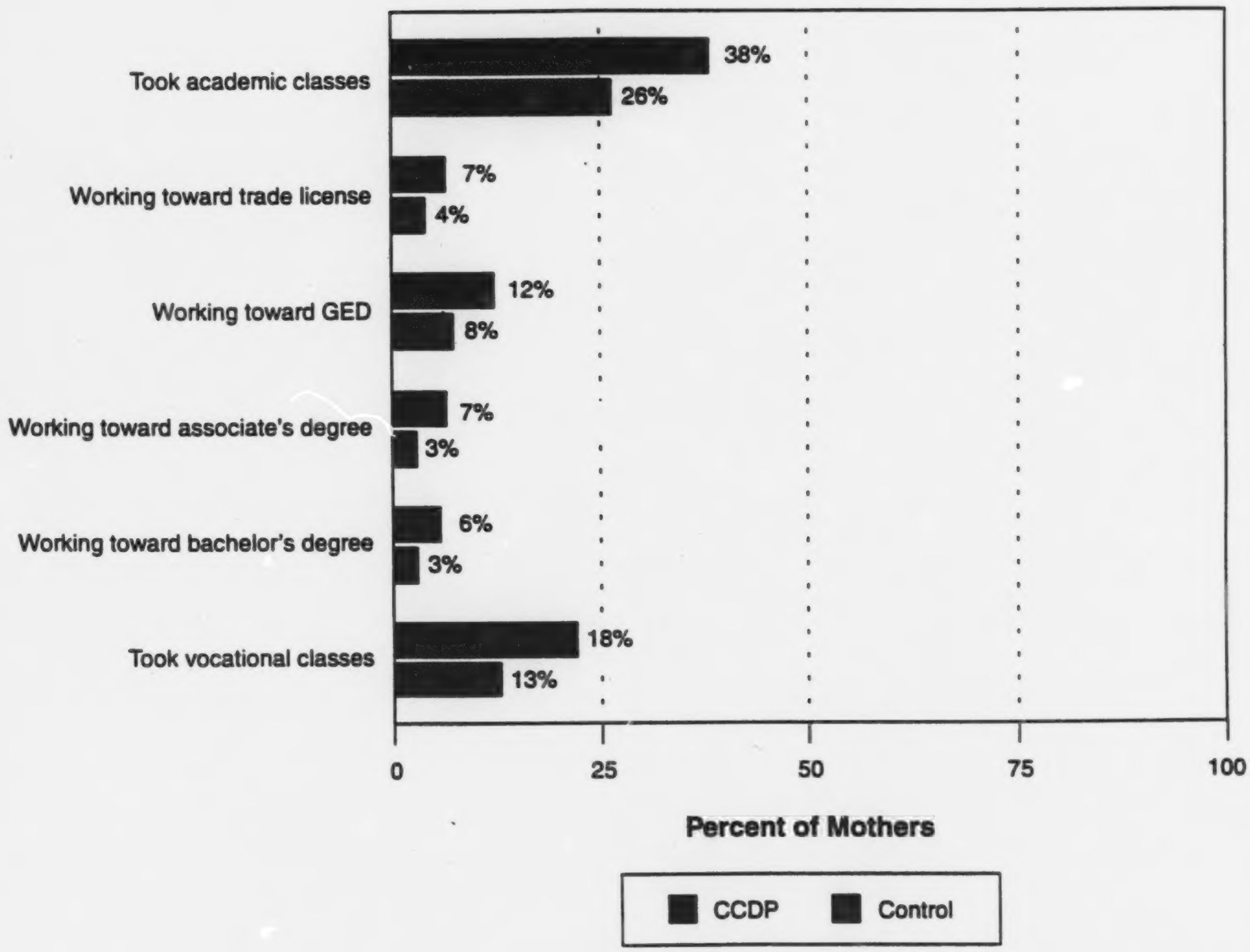
The assessment of individual mothers' economic dependency first involved measuring self-reported, preliminary steps toward self-sufficiency, including participation in academic or vocational/job training classes.

CCDP projects encourage participation in a range of educational classes and training programs, and there were large, positive changes in these areas, as seen in Exhibit 10-3 following this page. When compared to mothers in the control group, CCDP mothers were more likely to have taken academic classes (38 percent versus 26 percent); to have spent more time in academic classes (average of 9.4 hours per month versus 6.2 hours per month); and to be working toward a degree of some sort (32 percent versus 18 percent), including a trade license or certificate (7 percent versus 4 percent), a GED certificate (12 percent versus 8 percent), an associate's degree (7 percent versus 3 percent), or a bachelor's degree (6 percent versus 3 percent). CCDP mothers also were more likely than mothers in the control group to have taken vocational classes in the past year (18 percent versus 13 percent) and to have spent more time in vocational classes (3.5 hours per month versus 2.5 hours per month).

The mothers were asked similar questions about their live-in partners. The results indicate that CCDP has had some positive changes for the live-in

Exhibit 10-3

Summary of Effects on Mothers' Receipt of Economic Self-Sufficiency Services*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

partners, but they were considerably fewer and smaller than the changes for the mothers. As reported by participating mothers, live-in partners in CCDP families were more likely than their control group counterparts to have received a GED or high school diploma during the past year and to be working toward an associate's or bachelor's degree. They also were more likely to have participated in vocational classes.

The findings that CCDP has increased rates of participation in academic classes and in vocational/training classes show that CCDP projects have been able to increase the utilization of services designed to enhance economic self-sufficiency.

PHYSICAL HEALTH SERVICES FOR CHILDREN

At each measurement point, information was obtained from the mothers that allowed construction of indices of (1) preventative health care, including child immunizations and dental care; (2) incidence of dental caries identified in the last year; and (3) frequency of child health and dental services received.

Data on changes in health services for children are summarized in Exhibit 10-4 following the next page. The mothers reported that a significantly greater percentage of CCDP children than control group children had been to a doctor for a checkup during the past year (87 percent versus 84 percent). However, there was no difference in the percentage of children who had been seen by a doctor for an acute condition (66 percent), a chronic condition (7 percent), or any other problem (7 percent).

According to maternal reports, 12 percent of the children in the evaluation visited the dentist at least once during the past year; there was no CCDP/control group difference in this estimate, as seen in Exhibit 10-4. Given that the data collection occurred when children were about 24 months of age, it is not surprising that only a small proportion had ever been seen by a dentist. By the time children reach 36 or 48 months of age, it is expected that a much larger percentage of them will have visited a dentist. At that point, it will be more reasonable to expect to see CCDP/control group differences.

DEVELOPMENTAL SERVICES FOR CHILDREN

All of the CCDP projects provide services designed to improve children's development. The nature of the services varies, depending on the age of the child. For infants, child development services typically are delivered through home visits, while center-based services are more common for older children.

The mothers were asked to report on the developmental services provided to their children. Questions were asked about whether the children were treated for diagnosed learning problems, the focus children's participation in early childhood development programs, and participation by siblings in early childhood education. Findings appear in Exhibit 10-5.

Four percent of the CCDP mothers and 3 percent of the control group mothers noted that their children had diagnosed learning problems. Because the groups were randomly assigned, there is no reason to believe that CCDP children had more learning problems than control group children, so this finding suggests that CCDP may have been responsible for improving the rate of diagnosis of learning problems in participating children.

The data show large differences in the area of early childhood development services, indicating that CCDP has been successful in obtaining child care for program participants, especially work-related child care in formal settings.

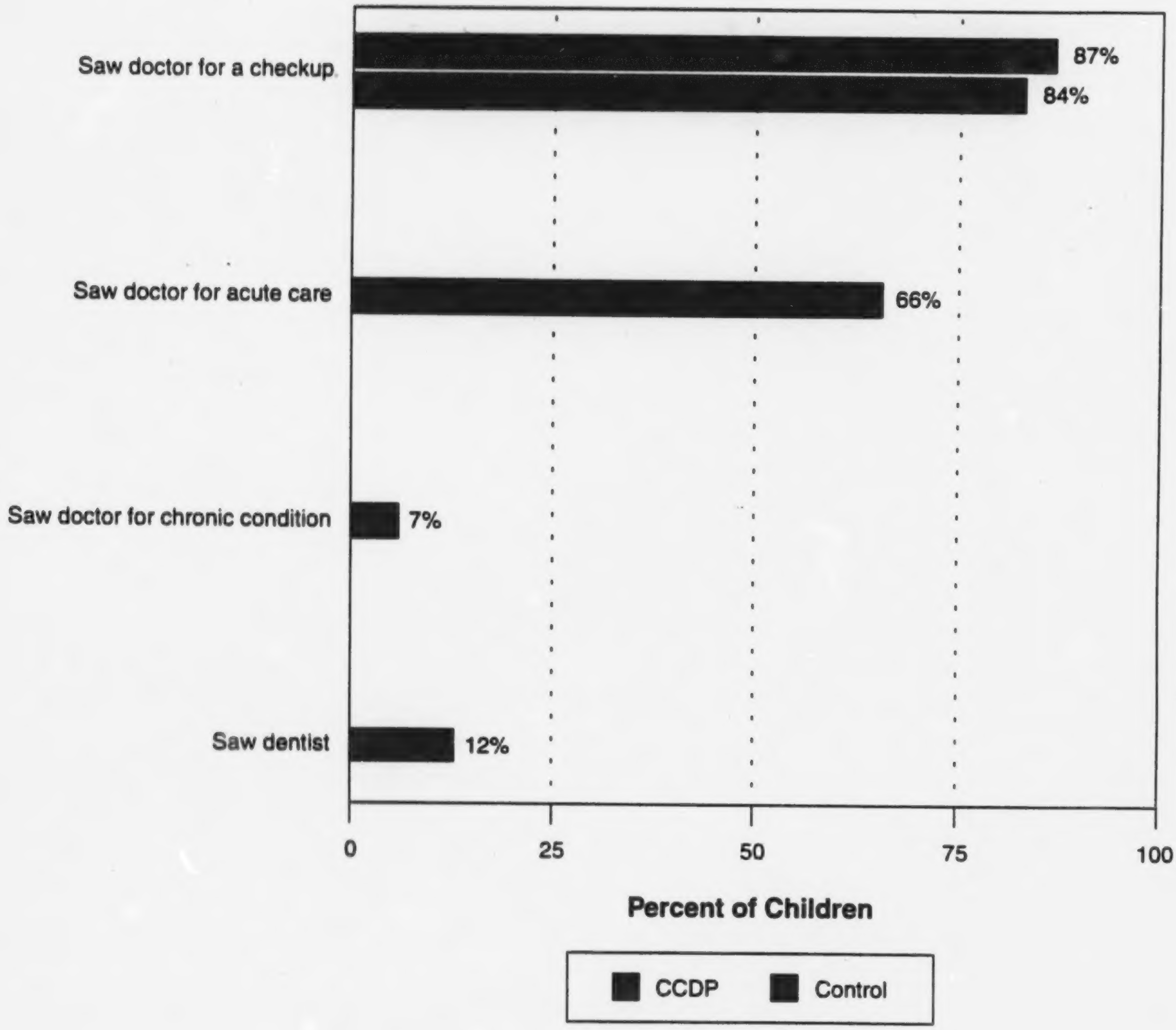
The mothers were asked a series of questions about the early childhood development services that they had used. First, they were asked about work-related child care—whether anyone else had cared for the focus child or whether the focus child had been in a program while the mother worked, looked for work, or was in school. Significantly more CCDP mothers than control group mothers responded that they had used some form of work-related child care (66 percent versus 53 percent). When asked additional questions about the type of work-related child care that was used, more CCDP mothers than control group mothers (36 percent versus 16 percent) had used formal child care (e.g., Head Start) or informal child care (e.g., intermittent or unstructured day care—for example, care by relatives during emergencies). Finally, the CCDP mothers indicated that their children had spent more time during the preceding 12 months in work-related child care than did the children of control group mothers (about 3 months versus about 1 month).

The mothers also were asked questions about their use of any other child care not related to work or schooling. Twenty-five percent of the CCDP mothers indicated that they had used nonwork-related child care, compared to 13 percent of the control group mothers. As was the case for work-related child care, the CCDP children spent more time during the preceding year than the control group children in nonwork-related child care (about 1.6 months versus 0.5 months).

At this point in the evaluation, few siblings born subsequent to the focus children are old enough to be receiving early childhood education services. Hence, this topic area will not be addressed until the final report from this study.

Exhibit 10-4

Summary of Effects on Children's Receipt of Health Services*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

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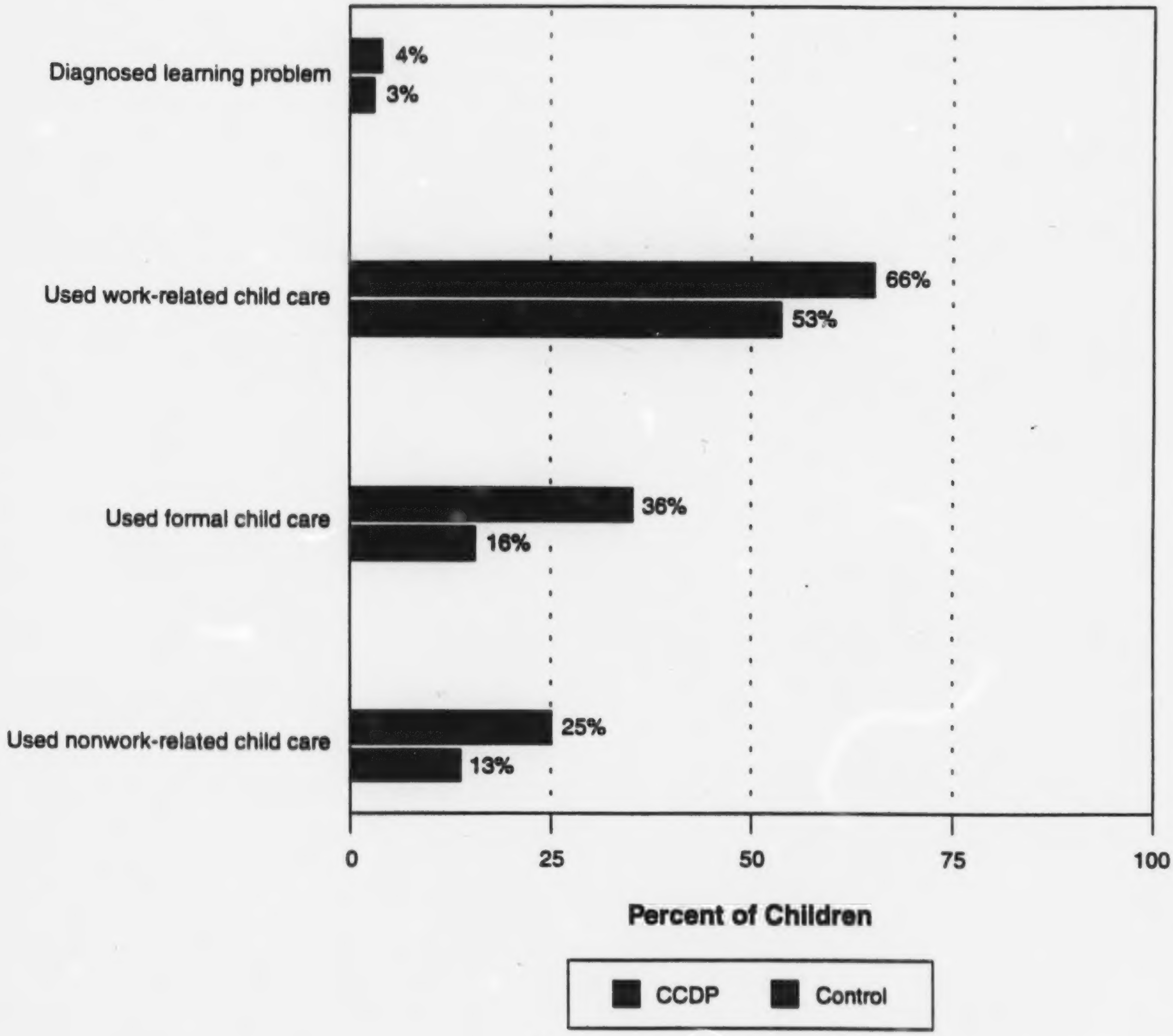
Exhibit 10-5

Summary of Effects on Children's Receipt of Developmental Services*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

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Chapter 11. EFFECTS ON MOTHERS, FAMILIES, AND CHILDREN

This chapter describes the preliminary effects of the Comprehensive Child Development Program (CCDP) on mothers, families, and children after 2 years of program operation. The first part of this chapter presents a summary of key findings to date. The subsequent discussion reports statistics that describe outcomes for both the CCDP group and the control group. Findings for mothers are presented in the following areas: physical health, mental health, parenting skills, and economic self-sufficiency. Findings for families are presented in the following areas: child/household stability, social supports/family problems, and quality of the home environment. Finally, findings for children are presented in the areas of physical health, cognitive development, and social-emotional development.

SUMMARY OF EFFECTS

In the short run, CCDP appears to have led to many statistically significant improvements in the lives of mothers and their children. As reported in the previous chapter, large changes were observed on services received by CCDP participants—case management services, mental health services, parenting education services, and services designed to enhance mothers' economic self-sufficiency. Though statistically significant, the effects observed on outcomes for CCDP participants were generally small in magnitude. This is not unexpected at this early date in the life of the CCDP projects and also due to the fact that the evaluation sample includes some families that participated in CCDP anywhere from a few days to the full two years. The combination of large, statistically significant increases for services received and small, statistically significant effects on several dimensions of parent and child outcomes would be expected, and this is consistent with hypotheses suggesting that it is necessary to affect services utilization and short-term outcomes before it is possible to affect longer term effects.

The following are key findings regarding the effects of CCDP on mothers, families, and children in the specified areas:

- *Maternal physical health.*—There was no observed effect on reported overall health status or on health habits of mothers in CCDP. At the time they were interviewed, 31 percent of all the mothers in the evaluation sample had given birth to a child subsequent to the focus child. Among women in this group, 71 percent saw a doctor in the first trimester of pregnancy. CCDP had no effect on this already high rate. Mothers who participated in CCDP and who had a subsequent pregnancy (1) delayed the pregnancy longer, (2) reported that they drank less during the pregnancy, (3) had heavier babies, and (4) had babies who spent fewer nights in the hospital and were less likely to require special care than their counterparts in the control group.

- *Maternal mental health.*—There was no evidence of positive effects on reducing depressive symptoms, building a locus of control, or enhancing the positive outlook of CCDP mothers.

- *Maternal parenting skills.*—Using a self-report scale which assessed beliefs about parenting, CCDP mothers were more likely than control group mothers to report empathetic awareness of their children's needs and were more likely to understand appropriate punishment strategies, including alternatives to corporal punishment. These are indications that CCDP may be reducing the parental attitudes that, in past research, have been linked to abusive and neglectful behaviors.

  CCDP mothers reported that they spent significantly more time with their children than did the control group mothers. Also, resident fathers in CCDP families spent more time looking after and doing daily activities with their children than fathers in control group families. In addition, CCDP mothers reported that they believed that their children were more likely to go further in school (i.e., would attend college) and that they were more likely to do better (i.e., would do above average) while in school than did control group mothers.

  Additional evidence about CCDP's effects on mother-child interactions comes from direct observations of a mother-child teaching task. CCDP mothers were observed to be more sensitive than their control group counterparts to cues given by their children, responded more appropriately to signals of distress on the part of their children, and acted in a manner fostering social-emotional growth in their children. None of these effects is large but all are statistically significant. Furthermore, all effects are consistent with the increased participation of CCDP mothers in parenting activities; CCDP appears to be helping mothers become better teachers of their children.

- *Maternal economic self-sufficiency.*—There were no effects observed across several areas related to economic self-sufficiency, such as problem-solving, life skills, and social connectedness. However, an important positive effect was found on engagement in literacy activities inside and outside the home: CCDP mothers were more likely than control group mothers to engage in literacy activities, including belonging to clubs, having hobbies, reading magazines, visiting the library, reading the newspaper, and having a library card.

  CCDP has had important positive effects on mothers who were not working at the time of their interviews. CCDP mothers were less likely than control group mothers to worry about the effects of working on their children and less likely to say that finding or affording day care was a problem. CCDP mothers who were working reported greater satisfaction than control group mothers with several aspects of their jobs.

There were no CCDP/control group differences in terms of either personal income (for mothers) or total earned household income. However, CCDP families were more likely than control group families to have received Aid to Families with Dependent Children (AFDC) or general assistance during the past year and were more likely to have received food stamps. Furthermore, as noted earlier, CCDP mothers were more likely than control group mothers to be enrolled in several different types of educational classes and training programs—these are activities which, in the long run, may be expected to lead to reduced AFDC and food stamp participation.

These income-related findings make sense in that CCDP is not expected to have a short-term impact on personal or household income. However, it is expected that CCDP case managers, in their role as family advocates, will ensure that families who are eligible for government assistance receive that assistance. In the long run, one of the goals of CCDP is to achieve positive impacts on employment and income, with a resulting decrease in reliance on government assistance.

- *Child/household stability.*—CCDP children were more likely than control group children to have their biological fathers in the household or to have biological fathers or other father figures in residence.

- *Child health.*—CCDP has had small but positive effects on the health of participating children. As opposed to their counterparts in the control group, children participating in CCDP were more likely to see a doctor for preventive health care, were more likely to have completed immunization schedules and to have had appropriate immunizations, were more likely to use seatbelts regularly, and were more likely to have experienced fewer hospitalizations for injuries and spent less time in the hospital when injured. These findings indicate that CCDP children have been using health services more consistently and appropriately than control group children. In addition, CCDP children have been receiving more preventive care and have been spending less time in the hospital for injuries.

- *Child development.*—CCDP has had positive but small effects on children's development. CCDP does not provide an intensive infant stimulation program, and one might not expect that program effects on cognitive development could be detected at 2 years of age. Even so, children in CCDP scored higher than control children on the Bayley Scales of Infant Development, a widely accepted measure of cognitive development. Though statistically significant, the effect on the Bayley is small—a 2-point average difference on the scale. In addition to the positive effect on the Bayley, children in CCDP were reported to have exhibited more prosocial behaviors (e.g., were cooperative and followed rules).

The remainder of this chapter discusses in depth the measures and outcomes for mothers, families, and children from both the CCDP group and the control group in the areas outlined above.

MATERNAL PHYSICAL HEALTH

This section discusses the measures used and the outcomes in the area of maternal physical health, including effects on physical health status, health habits, and subsequent pregnancies.

Measures

Information on maternal health was collected through self-reporting rather than direct assessment. Outcome areas that were measured in the area of maternal physical health include chronic illness, health habits, pregnancy behavior, spacing of pregnancies, and health problems and outcomes resulting from subsequent pregnancies. In addition, the mothers were asked to provide an overall rating of their own physical health. All of these topics were examined as part of a self-report parent interview. Maternal substance use was examined through self-reports on the frequency of use (including use during pregnancy) of cigarettes, alcohol, and nonprescription drugs. The mothers also were asked about problems associated with alcohol or nonprescription drug use by other members of the household.

Effects on Physical Health Status

The mothers were asked to rate their overall health status. As seen in Exhibit 11-1 following this page, most of the program and control group mothers (83 percent) rated their health as "good," "very good," or "excellent," while only 17 percent rated their health as "fair" or "poor."

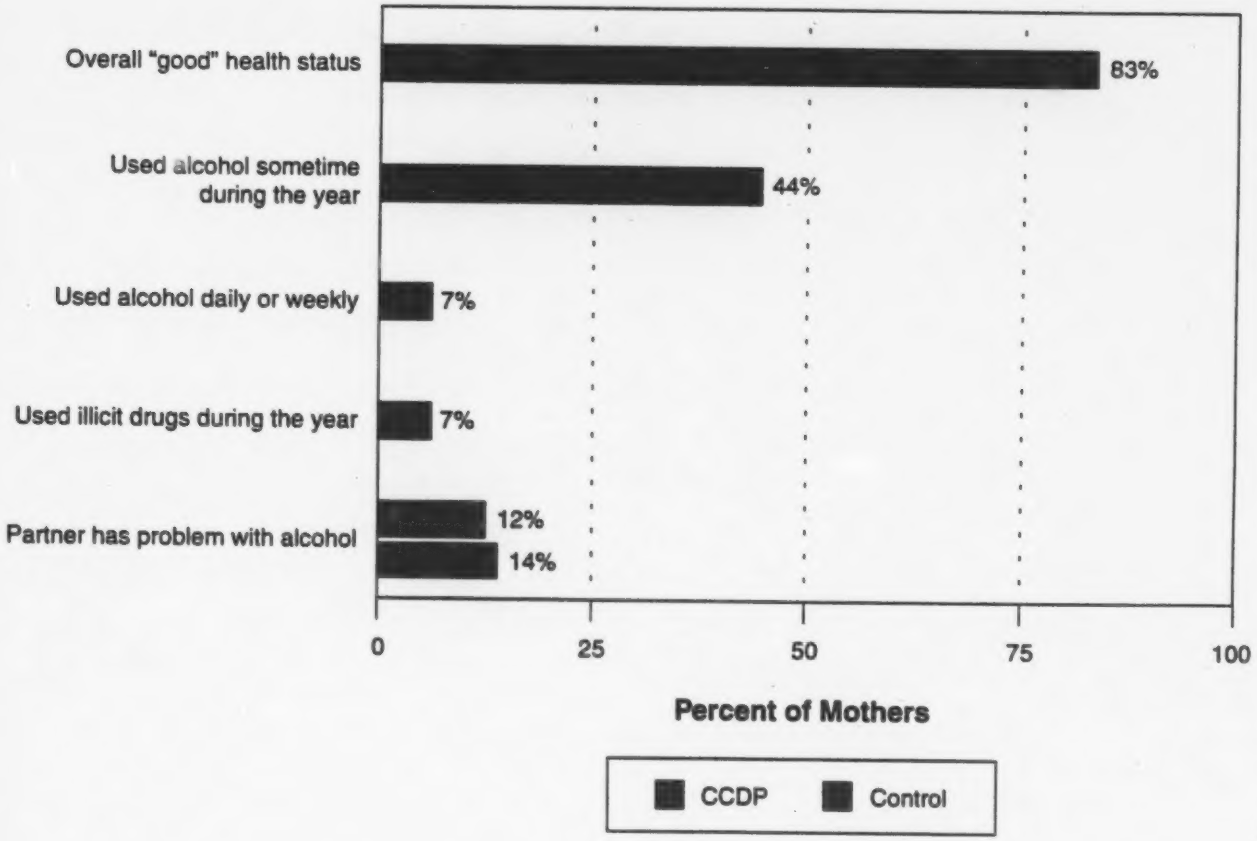
Effects on Health Habits

The mothers were asked a series of questions about their use of alcohol and other drugs during the previous year. As shown in Exhibit 11-1 following this page, 44 percent reported that they used alcohol and 7 percent reported use of an illicit drug at some point during the year (7 percent used marijuana, and 2 percent used drugs such as heroin or cocaine). Furthermore, 7 percent reported that they used alcohol on a daily or weekly basis during the year. There was no program/control group difference on any of these measures.

When asked whether use of alcohol or drugs had led to any problems with family, health, legal institutions, or work, 10 percent of the mothers

Exhibit 11-1

Summary of Effects on Maternal Health Outcomes*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

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reported some problems attributable to alcohol use, 3 percent reported problems attributable to use of marijuana, and 1 percent reported problems due to use of hard drugs. Again, there were no differences between the program and control groups on these measures.

When asked about their partners' use of alcohol or illicit drugs, 14 percent of the control group mothers reported that their partners had problems with alcohol, compared to only 12 percent of the program mothers (a significant program effect). Five percent (for both program and control groups) reported that their partners had problems with drugs.

Effects on Subsequent Pregnancies

One of CCDP's aims is to encourage more informed pregnancy-related behaviors among participating women. Research has shown that, among low-income women, a single pregnancy provides serious, but not insurmountable, obstacles to completing high school and achieving economic self-sufficiency. However, additional pregnancies greatly decrease the probability of a mother completing her education and becoming economically independent.

At the time of the maternal interview, 31 percent of the mothers (for both program and control groups) reported a birth subsequent to the birth of the focus child. Seventy-one percent of all mothers reported that they first availed themselves of prenatal care by the third month of their pregnancies, as seen in Exhibit 11-2 following the next page. This is early during pregnancy, and it would be difficult for CCDP to make a difference in this measure. A summary of the effects on subsequent pregnancies also is presented in Exhibit 11-2.

On average, there were 1.5 years between the births of the focus child and a subsequent birth. However, subsequent births for CCDP mothers occurred an average of 26 days later than births for control group mothers, indicating that CCDP may have resulted in delayed pregnancies.

There were no differences between CCDP and control group mothers in terms of whether they smoked (26 percent in both groups) or consumed any alcohol (10 percent in both groups) during subsequent pregnancies. However, when they drank, CCDP mothers reported using less alcohol than did control group mothers.

Thirty-two percent of babies born after the focus child to CCDP and control group mothers were born preterm by an average of 1.2 weeks. Twenty-one percent of CCDP mothers reported a serious problem with the pregnancy, compared to 16 percent of control group mothers. However, there is no reason to expect CCDP programs to cause an increase in pregnancy-related problems; therefore, this finding more likely indicates an increased awareness of and attention to pregnancy problems on the part of CCDP mothers.

Babies born to CCDP mothers weighed an average of 3,255 grams (7.2 pounds), which is significantly more than the 3,183-gram average (7.0 pounds) for babies born to control group mothers. However, with respect to the incidence of low-birthweight infants, there was no difference between CCDP and control group babies: Ten percent of each group weighed less than 2,000 grams.

Mothers in both groups spent the same average amount of time in the hospital after giving birth (i.e., 2.4 days). Thus, the increased identification of pregnancy-related problems on the part of the CCDP group noted above did not translate into any additional time for the mother in the hospital. However, babies born to CCDP mothers spent fewer nights in the hospital than their control group counterparts (an average of 3.6 nights versus 5.0 nights), and they were less likely to require special care (11 percent versus 15 percent). This is an important and relatively large effect. Consequently, combined with the above results, it appears that CCDP mothers to date have had heavier and healthier babies.

MATERNAL MENTAL HEALTH

This section discusses the measures used and the outcomes in the area of maternal mental health, including effects on depression, locus of control/mastery, and positive outlook.

Measures

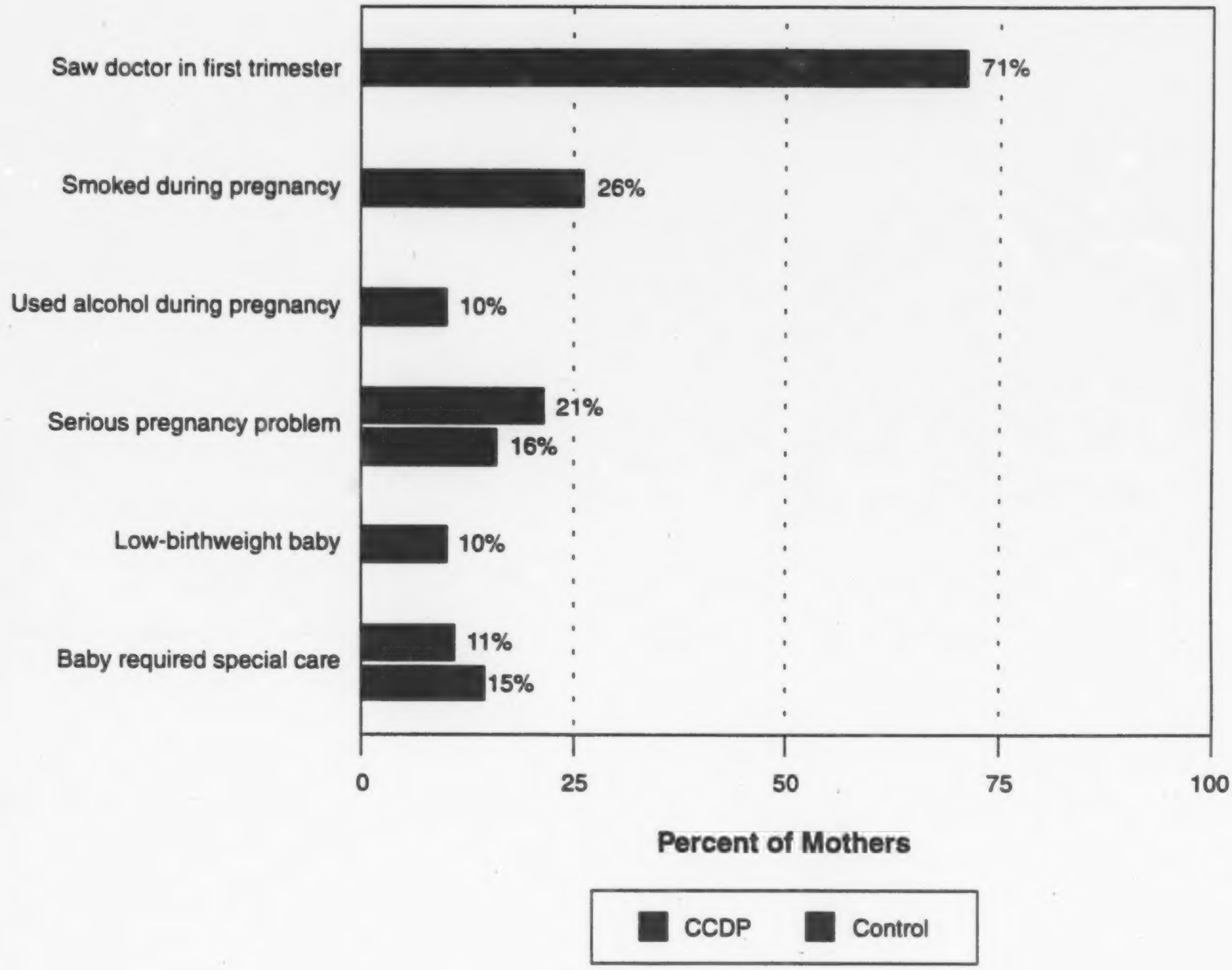
Data on three aspects of the mothers' mental health—(1) depression, (2) general life outlook, and (3) sense of mastery (or locus of control)—were collected through the maternal interview. Maternal depressive symptoms were measured using the Center for Epidemiological Studies' Depression Scale (CES-D) (Radloff, 1977). The scale has been used frequently in psychological research, is short (a total of 20 items), has adequate psychometric characteristics, and can be used to distinguish mild from severe depressive symptoms. The scale includes statements such as, "I felt that everything I did was an effort," "I had crying spells," and "I enjoyed life." Respondents are asked to indicate how often they experienced each feeling during the past week. Items are rated on a 4-point scale from "rarely or none of the time—less than one day" to "most or all of the time—5 to 7 days."

In addition to the CES-D, a subset of items from the Rand Mental Health Inventory that assess "general positive affect" also was administered to participating mothers. These items allow an assessment of each mother's general outlook and satisfaction with life.

Finally, sense of mastery was assessed through the Pearlin and Schooler Mastery Scale (Pearlin and Schooler, 1978). This scale measures the extent

Exhibit 11-2

Summary of Effects on Subsequent Pregnancies*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

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to which an individual regards his/her life as being under one's own control rather than determined by fate. The scale includes a mix of positive and negative items and has high internal consistency (Cronbach's alpha of 0.81). The scale consists of seven items such as the following: "There is really no way I can solve some of the problems I have" and "I can do anything I really set my mind to." The respondent is asked to rate each item on a 4-point scale from "strongly agree" to "strongly disagree."

Effects on Depression

Depressed persons typically have higher scores on the CES-D than persons who are not depressed. A score of 16 or above is an indicator of clinical depression (Hall et al., 1985). Mothers in both the CCDP and control groups had average CES-D scores of 15, indicating a high level of depression in both groups as a whole; 42 percent of mothers in both study groups had scores of 16 or above, which is defined as being clinically depressed. Hence, CCDP does not appear to have had any short-term effect on mothers' depression levels. This is consistent with the findings of other studies (e.g., St. Pierre et al., 1993), which indicate that changes in reported levels of depressive symptomatology are very difficult to achieve and often require a long period of time.

Effects on Locus of Control/Mastery

There was no difference between the mastery scale scores of mothers in CCDP and in the control group, indicating that at the time of data collection, CCDP had not made an observable difference in the loci of control of participating mothers. Although low-income parents might be expected to score low on this measure, mothers in the combined evaluation sample scored an average of 20.5 on the locus of control scale, which has possible scores ranging from a low of 7 to a high of 28. This relatively high average score indicates that CCDP may have a difficult time making any improvements in mothers' loci of control.

Effects on Positive Outlook

A measure of positive life outlook was constructed from items taken from the Rand Mental Health Inventory. Mothers in CCDP and in the control group rated themselves an average of 3.1 out of a possible 10 on this scale, indicating that they do not have particularly positive outlooks on life. Clearly there is room to improve in this area, but at this early point in time, CCDP has had no measurable effect on mothers' life outlooks.

MATERNAL PARENTING

This section discusses the measures used and the outcomes in the area of maternal parenting, including effects on attitudes linked to abuse, expectations for the child, the mother-child relationship, and observed mother-child interaction.

Measures

The impact evaluation has assessed mothers' attitudes or beliefs about parenting and evaluated the mother-child relationship using two different types of measures. First, as part of the maternal interview, the mother was asked to describe her relationship with her child and the child's relationship to the father. Second, a brief, structured observational session was conducted by a trained observer with the mother and child engaged in a teaching situation.

Beliefs about parenting were assessed with the Adult-Adolescent Parenting Inventory (AAPI) (Bavolek, 1989). The AAPI is an inventory designed to assess the parenting and childrearing attitudes of adults and adolescents. The instrument consists of 32 items that measure parenting patterns commonly thought of as abusive and neglectful. Prior analyses have identified four constructs in the AAPI: (1) inappropriate expectations, (2) lack of empathy, (3) belief in the value of corporal punishment, and (4) role reversal. The AAPI has been shown to have adequate reliability and has been used in other studies with similar populations.

The mother-child relationship was assessed through interview items addressed to the mother about both her relationship and the father's relationship to the child. For resident fathers, questions examined the types and frequency of father-child activities and the mothers' assessments of the relationship. For nonresident fathers, additional questions were asked about the frequency of their contacts with their children. Finally, mothers were asked about their expectations for their children's educational achievements.

The mother-child relationship also was assessed directly through a structured observation conducted as part of the child assessment. Each mother was asked to teach her child a simple task similar to the performance tasks on the Bayley Scales of Infant Development. The observer completed a rating of the teaching interaction based on observation. A standardized rating system, the Nursing Child Assessment Teaching Scale (NCATS) (Barnard, 1989), was used by the trained observer to assess critical features of parent-child interaction.

NCATS was developed in 1972 by a team of psychologists, physicians, and nurses. The scale is intended for use, after relatively straightforward training, by health professionals in a variety of settings. Revised in 1976, the 73 binary-item scale is designed to describe (1) the repertoire of behaviors brought into a structured teaching interaction by both members of the parent-child dyad and (2) the contingency of their responses to each other. The scale also describes less obvious aspects, such as child positioning and subtle negative cues from the child. The tasks used in the teaching interaction were taken primarily from motor performance items in the Bayley Infant Scales and, at later ages, from the Merrill-Palmer and Stanford-Binet Scales. The 73 items were summed to yield a child score (reflecting clarity of cues and responsiveness to the mother) and a mother score (reflecting her sensitivity, her alleviation of the child's distress, etc.).

Effects on Attitudes Linked to Abuse

Research has shown that certain parental attitudes often are linked to abusive and/or neglectful behaviors. The AAPI has four scales measuring such attitudes. There were positive program effects on two of the four AAPI scales. CCDP mothers were more likely than control group mothers to report empathetic awareness of their children's needs and were more likely to report an understanding of appropriate punishment strategies, including appropriate alternatives to corporal punishment (as seen in Exhibit 11-3 following the next page). The remaining two scales examine (1) expectations for the child's behavior and (2) understanding of appropriate roles for the mother and the child. There were no effects of the CCDP program on these latter two scales.

Effects on Expectations for the Child

Expectations for the children's educational achievement were measured using a set of survey items. Compared to mothers in the control group, CCDP mothers indicated that they believed their children would go further in school (were more likely to attend college) and that they would do better while in school (were more likely to do above average). In an additional item, each mother was asked how likely she believed it was that her child would graduate from high school. On a scale ranging from 1 to 4 (with 4 being the highest), the average rating for both the CCDP and control group mothers was 3.8, indicating that almost all the parents (program and control) reported the belief that their children would graduate from high school.

Effects on the Mother-Child Relationship

Each mother was asked a series of questions about her relationship to the focus child. The CCDP mothers reported that they spent significantly more time with their children in child-focused activities than did the control group mothers. However, there was no difference between the mothers in the two groups in terms of how close they reported feeling to their children.

The mothers also reported on the relationship between the focus child and the resident father or father figure. Resident fathers in CCDP families were reported as spending more time looking after their children and more time on child-focused activities than fathers in control group families. There were no program/control group differences in terms of reported time spent playing with the child, time spent talking with the child, or perceived closeness to the child.

Effects on Observed Mother-Child Interaction

The data summarized in Exhibit 11-4 show that CCDP mothers had higher total teaching scores than control group mothers on the NCATS teaching scale; there was no program/control group difference for children's interactive behavior, and none would be expected at this early age. When observed in a teaching situation with their children, the CCDP mothers displayed greater sensitivity than their control group counterparts to cues given by their children (e.g., praised the child, gave instructions when the child was attentive, and positioned the child so that he/she could reach the materials), responded more appropriately to signals of distress on the part of the child (e.g., made positive/soothing verbalizations; rearranged the child's position; and did not yell at, slap, or hit the child), and acted in a manner that would foster social-emotional growth in the child (e.g., laughed or smiled, did not interrupt the child, and smiled or touched the child after the child smiled). There was no effect on the scale measuring whether the mother acted in a manner that would foster cognitive growth in the child.

None of these effects was large, but all were statistically significant, and all are consistent with the increased participation of CCDP mothers in parenting activities. CCDP appears to be helping mothers to become better teachers of their children.

ECONOMIC SELF-SUFFICIENCY

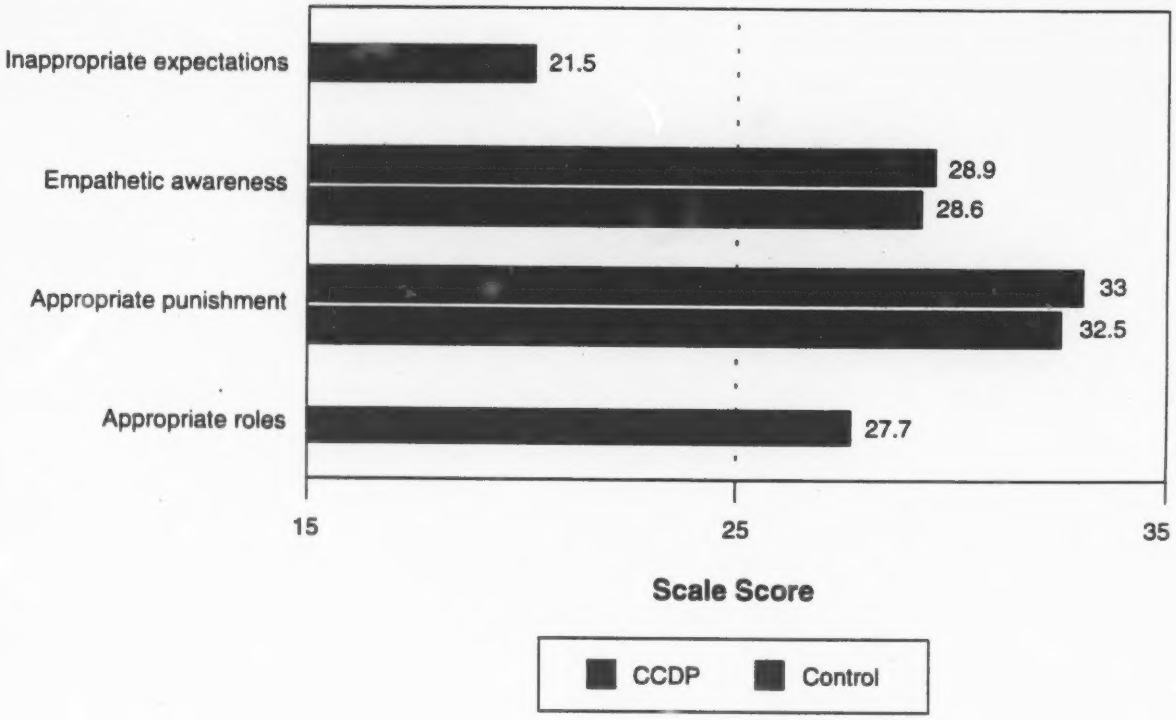
This section discuss the measures used and the outcomes in the area of economic self-sufficiency, including effects on employment and income, problemsolving strategies, life skills, social connectedness, work-related attitudes, and education certificates and degrees.

Measures

The life management and coping skills of participating parents are another key focus of CCDP services. Since most assessments of stress management skills are conducted within the context of clinical evaluations performed by social workers and health professionals, few standardized scales exist for these particular domains of functioning. The Ways of Coping Inventory (Carver and Schrier, 1989) was used to assess the ways in which the mothers respond to stress. The inventory includes 13 different subscales to measure conceptually distinct aspects of coping. Mothers in both groups were administered the following (of the 13) subscales considered to be most useful to the CCDP evaluation: Active Coping, Planning, Seeking Social Support for Emotional Reasons, Seeking Social Support for Instrumental Reasons, Religion, Mental Disengagement, and Behavioral Disengagement.

Exhibit 11-3

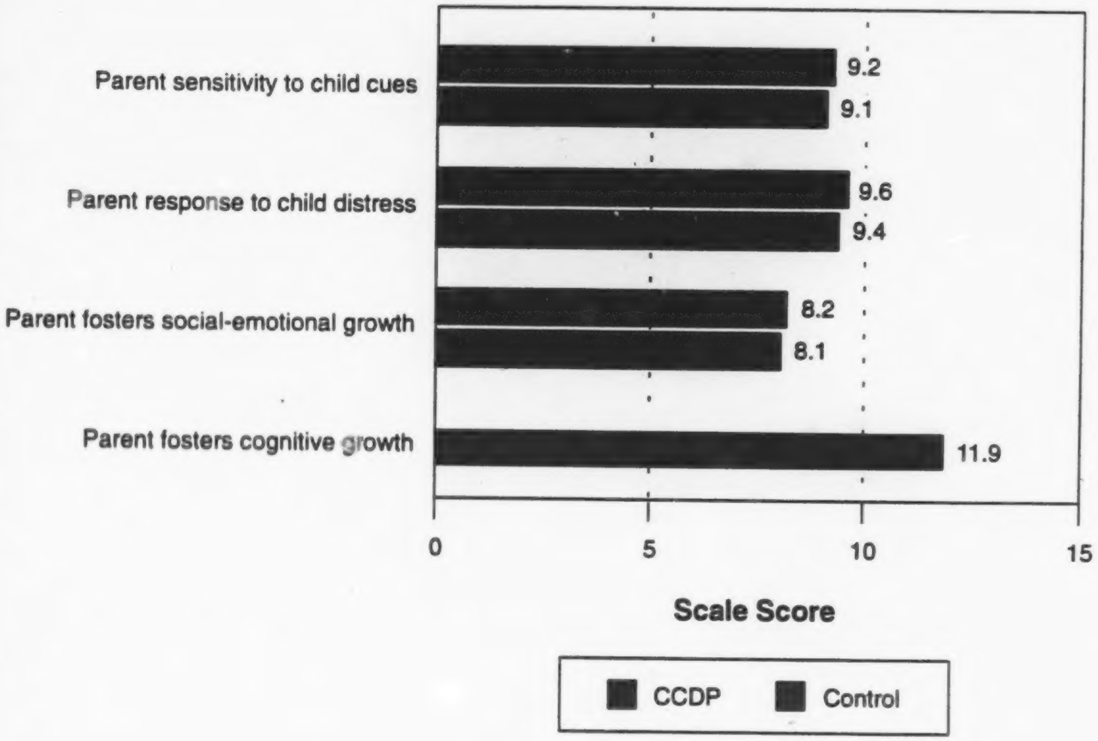
Summary of Effects on Maternal Attitudes Linked to Abusive and Neglectful Behaviors*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

Exhibit 11-4

Summary of Effects on Mother-Child Interaction (NCATS)*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

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Psychometric analyses of the Ways of Coping Inventory indicate adequate reliability.

In order to assess "social connectedness," researchers asked the mothers a series of questions assessing, problemsolving ability and access to resources. Three scales were constructed from these items: (1) a scale for instrumental support, which was based on seven items in which the mother was asked whether there was someone she could count on to help with food shopping, housecleaning, bills, and other household chores; (2) a scale for emotional support, which was based on nine items in which the mother was asked whether there was someone she could count on to comfort her, to take care of her when she was sick, to talk with her, and to help out in other similar ways; and (3) a scale for harmonious relationships, which was based on six items describing whether there were problems between the mother and her neighbors, the landlord, bill collectors, and other similar significant persons in her life.

Additional scales were built to assess "life skills," including a score for income based on 9 items requesting information about the mother's financial resources (e.g., had she been bothered by bill collectors, did she have enough money to buy food, and did she have a bank account); a score for efficiency in life operations, which was based on 13 items such as whether the mother has access to transportation, whether she had a telephone, and whether she got dressed in the morning; and a score for literacy activities, which was based on 6 items requesting information about such things as participation in clubs, whether the mother read the newspaper, and whether she read magazines.

As part of assessing the mother's progress toward greater economic self-sufficiency, the impact evaluation also assessed attitudes toward work. The assessment used items adapted from two standardized measures of work-related attitudes: the Job Description Inventory (Smith, Kendall, and Hulen, 1968) and the Minnesota Satisfaction Questionnaire.

Finally, an assessment was made of changes in employment over the course of the evaluation, changes in sources and amount of annual income, and changes in the type(s) and amount of government assistance the parent had been receiving.

Effects on Employment and Income

A series of interview questions were asked in order to determine the employment and income statuses of respondents. In addition, respondents were asked to report on the employment statuses of their live-in partners (where applicable). Twenty-nine percent of the mothers participating in the evaluation reported that they had a job at the time they were interviewed, with no difference between the program and the control groups (Exhibit 11-5). Seventy-one percent of respondents' live-in partners were reported to have a job, again with no program/control group difference. Also, there were no differences between the CCDP mothers and the control group mothers (or their live-in partners) in terms of the number of hours worked per week, the wages earned per week, or the number of months worked during the previous year.

By combining the 29 percent of mothers who had a job with the 23 percent who responded that they were looking for work, it can be seen that 52 percent of the mothers in the evaluation were actively involved in the labor market (no difference between the program and the control groups), while the remaining 48 percent were not currently participating in or looking for work. Similarly, 88 percent of the live-in partners were actively involved either in working or in looking for work.

A final series of questions was asked about personal and household income during the previous year and about reliance on government assistance. There were no CCDP/control group differences in terms of either personal income (for mothers) or total household income earned during the past year. However, the CCDP families were more likely than the control group families to have received AFDC, welfare, or general assistance during the past year (66 percent for the CCDP families versus 63 percent for the control families) and, in addition, were more likely to have received food stamps (81 percent for the CCDP families versus 78 percent for the control families). Furthermore, as noted earlier, the CCDP mothers were more likely than the control group mothers to be enrolled in several different types of educational classes and training programs—these are activities that, in the long run, may be expected to lead to reduced AFDC and food stamp participation.

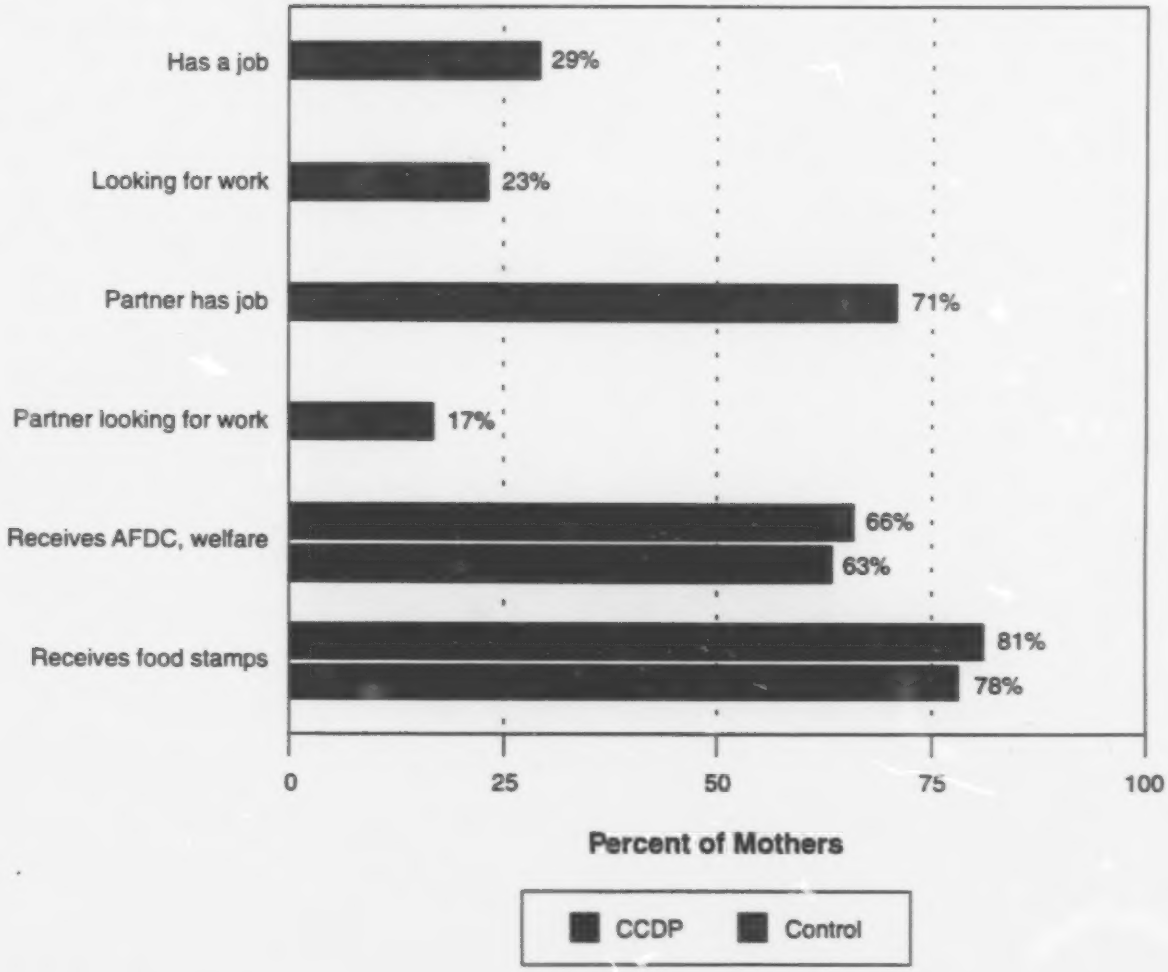
These income-related findings are not unexpected and are consistent with the expectation that while CCDP might not make short-term impacts on personal or household income, CCDP case managers—in their role as family advocates— would ensure that families who are eligible for government assistance received such assistance, particularly if the families are enrolled in school or job training. In the long run, CCDP hopes that increased participation in education and training programs will help achieve positive impacts on employment and income, with a resulting decrease in long-term reliance on government assistance.

Effects on Problemsolving Strategies

The Ways of Coping Inventory (Carver and Schrier, 1989) was used to ask the mothers to think about the ways in which they handle stress in order to measure the ability of those mothers to engage in a variety of problemsolving strategies. CCDP mothers exhibited significantly better problemsolving strategies than did the control group mothers on two of the seven coping subscales, as seen in Exhibit 11-6 following this page. Compared to the mothers in the control group, the CCDP mothers were more likely to report that they engaged in active coping behaviors (e.g., thought about a strategy to solve the problem) and were more likely to be

Exhibit 11-5

Summary of Effects on Mothers' Employment and Income*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

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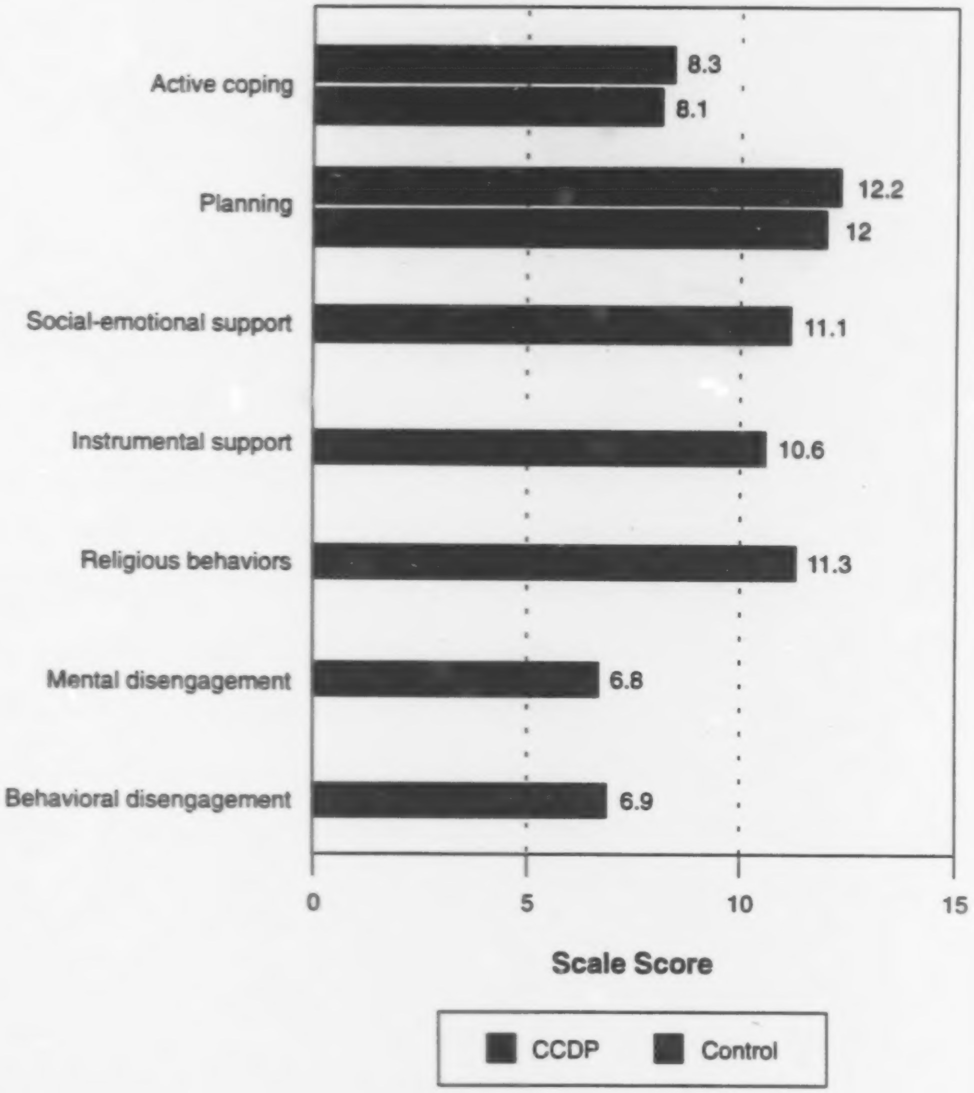
Exhibit 11-6

Summary of Effects on Mothers' Problemsolving Strategies*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

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able to plan solutions (e.g., make a plan of action). No CCDP/control group differences were noted for the following types of coping strategies: seeking social support for emotional reasons (e.g., to talk to someone about one's feelings), seeking social support for instrumental reasons (e.g., to get advice from friends or relatives), using religion as a coping mechanism (e.g., to put trust in God or pray a lot), mentally disengaging as a coping mechanism (e.g., to watch television or daydream), and behaviorally disengaging as a coping strategy (e.g., to quit trying and give up).

Effects on Life Skills

Several survey items were asked of the mothers in order to measure their abilities to find the resources to deal with everyday problems. CCDP's case managers work with participating families to ensure that they have mechanisms and skills in place to access the resources needed to carry on with life on a daily basis.

Exhibit 11-7 following the next page shows that there were no program/control group differences in reported life skills areas such as the ability to survive financially (e.g., have a credit card, not be bothered by bill collectors, have a bank account, and have enough money for food) and the ability to live efficiently (e.g., have transportation available, know the location of the bus stop, have a telephone, and eat meals regularly). On the other hand, CCDP mothers were more likely than control group mothers to engage in literacy activities (e.g., belong to clubs, have hobbies, read a magazine, visit a library, read a newspaper, and have a library card). Many of the activities in this last subscale are steps that have been shown to be associated with the subsequent achievement of basic functional literacy—an important building block for life skills.

Effects on Social Connectedness

As is shown in Exhibit 11-8, no effects of CCDP were found in the three measured areas of social connectedness, including (1) the ability to find instrumental support (e.g., having someone to count on for help with chores such as shopping, cooking, and cleaning), (2) the ability to find emotional support (e.g., someone to count on for comfort or for care when sick), and (3) the ability to have harmonious relationships (e.g., with neighbors, the landlord, or one's partner).

Effects on Work-Related Attitudes

The 48 percent of the mothers in the evaluation sample who were unemployed and not actively looking for work were asked a series of questions to determine why they were not seeking employment (see Exhibit 11-9). The CCDP mothers were much more likely than the control group mothers to report that they were not looking for work because they were in school (33 percent versus 19 percent). At the same time, CCDP appears to have had positive impacts on attitudinal barriers to work: the CCDP mothers were less likely than the control group mothers (52 percent versus 62 percent) to give reasons such as "I want to be at home taking care of my child," "My child is too young for me to work," "I don't want to work," or "I am afraid to put my child in day care." There was no effect of CCDP on economic reasons (e.g., no jobs available near home or no jobs that pay enough), on legal reasons (e.g., no working papers or identification to get a job), on instrumental reasons (e.g., not sure how to look for a job, not enough education, does not speak English, or has no way of getting to a job), or on life-related responsibilities (e.g., is pregnant, is moving, has had a recent death in the family, or has a disability).

As shown in Exhibit 11-10, the CCDP mothers were less likely than their control group counterparts (47 percent versus 53 percent) to agree with the statement, "It is better for babies if mothers stay at home and don't work." Most of the mothers (93 percent) in both groups agreed that "Working makes me feel better about myself"; 31 percent agreed with the statement, "The money I could make at work isn't worth the hassle"; and 38 percent agreed with the statement, "I don't want to go out and work at a job every day right now."

The mothers who had ever held a job were asked another set of questions that had to do with a variety of potential barriers that might make working difficult. Exhibit 11-11 shows that the mothers who participated in CCDP were less likely than the control group mothers to say that finding day care has been a problem (27 percent versus 38 percent) and that affording day care has been a problem (39 percent versus 49 percent). There were no differences between the two groups in the percentage of mothers who had problems finding transportation to work (17 percent), finding enough time for the children (27 percent), finding enough time for friends (9 percent), having the right clothes to wear (20 percent), finding enough time for family (21 percent), or dealing with a boss or supervisor (6 percent).

Mothers who had ever worked also were asked questions about how satisfied they were with their job, as seen in Exhibit 11-12 following this page. Mothers in CCDP were more likely than the mothers in the control group to be satisfied with the amount of work they were doing (85 percent versus 77 percent), to be satisfied with their pay (63 percent versus 54 percent), and to be satisfied with their chances of "moving up" (72 percent versus 63 percent). The mothers in the two groups did not differ in terms of satisfaction with their supervisors, with the importance of their work, with the people they worked with, with how interesting their work was, with their freedom to use their own judgment, or with the ease of changing things at work to fit their families' needs.

Effects on Education Certificates and Degrees

The mothers were asked a series of interview questions about their educational status and about the educational status of their live-in partner

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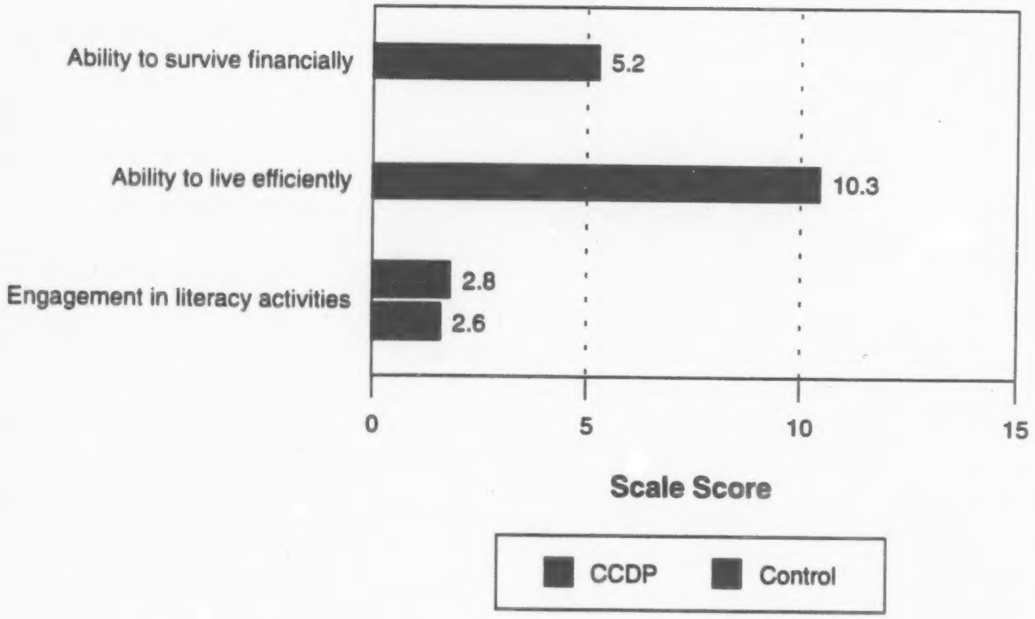
Exhibit 11-7

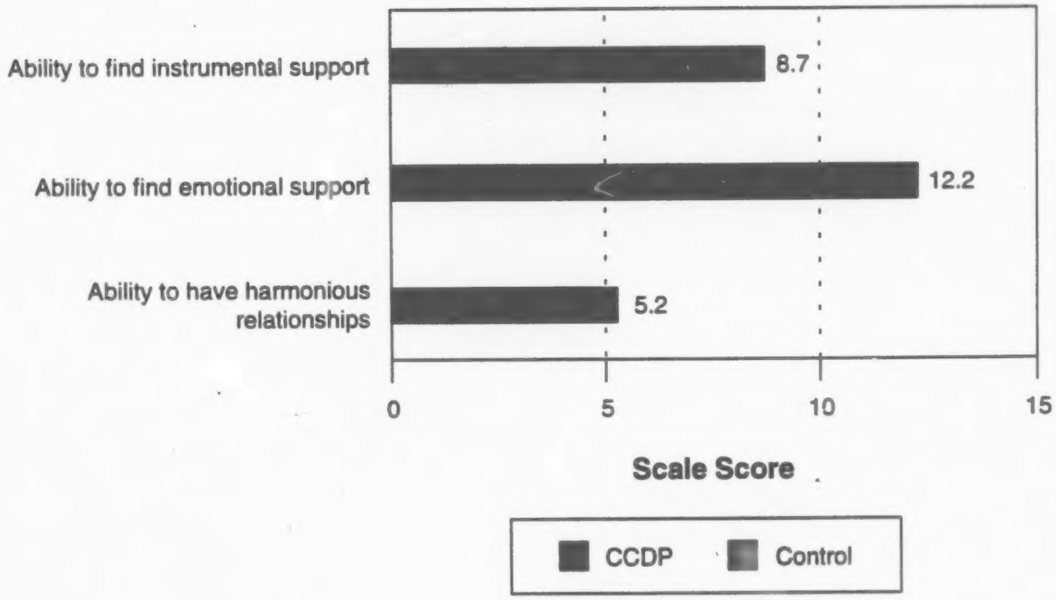
Summary of Effects on Mothers' Life Skills*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

Exhibit 11-8

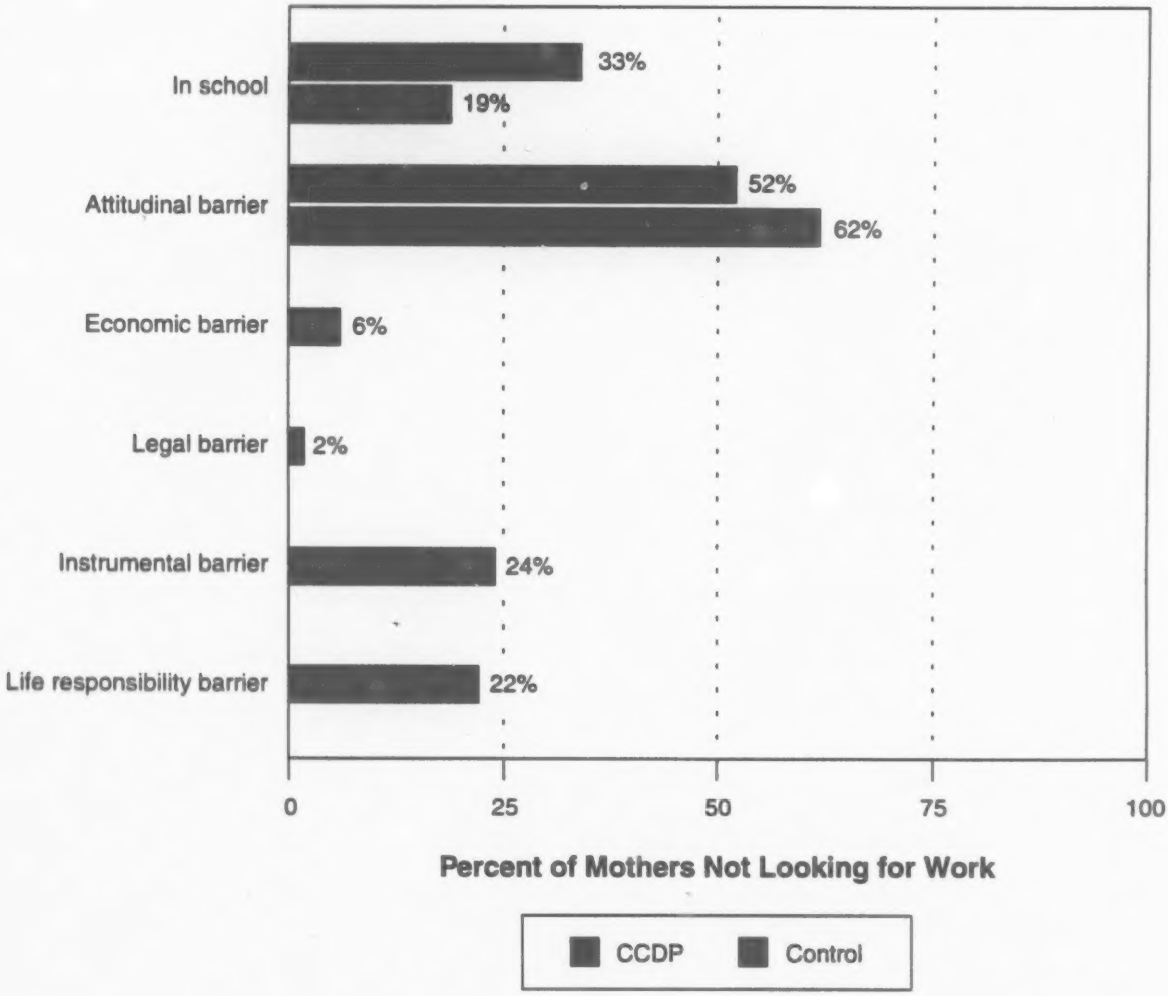
Summary of Effects on Parents' Social Connectedness*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

Exhibit 11-9

Summary of Effects on Nonworking Mothers' Reasons for Not Looking for Work*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

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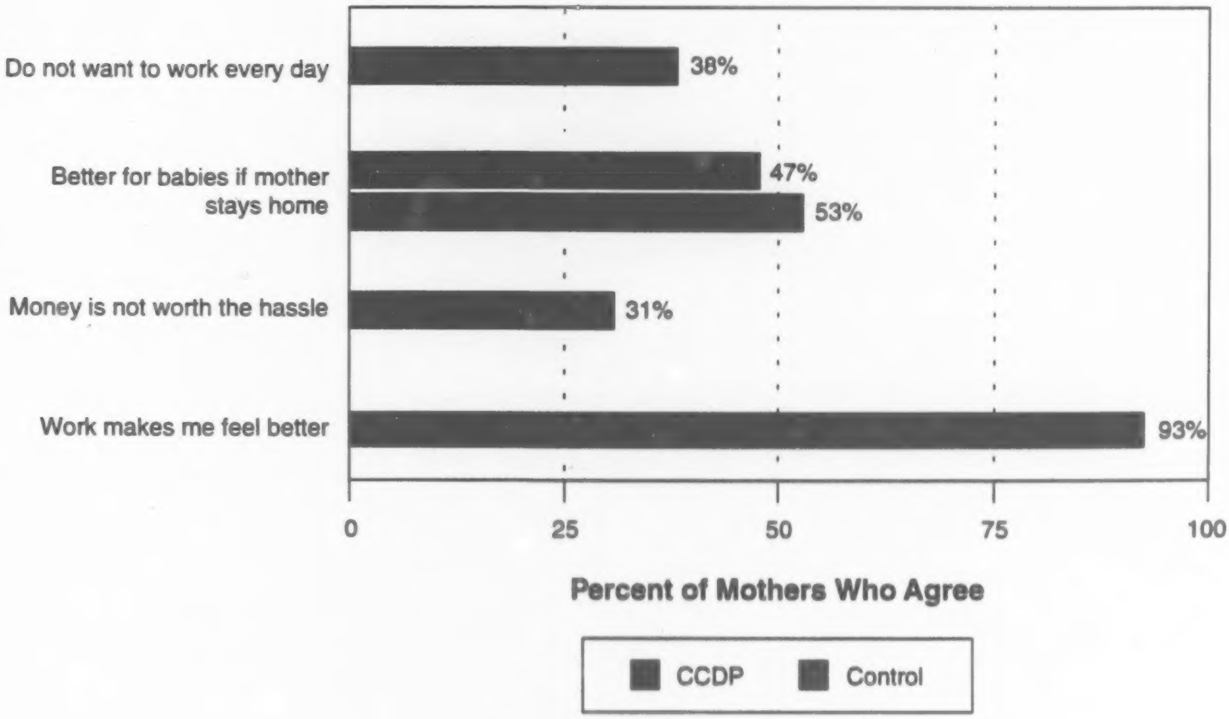
Exhibit 11-10

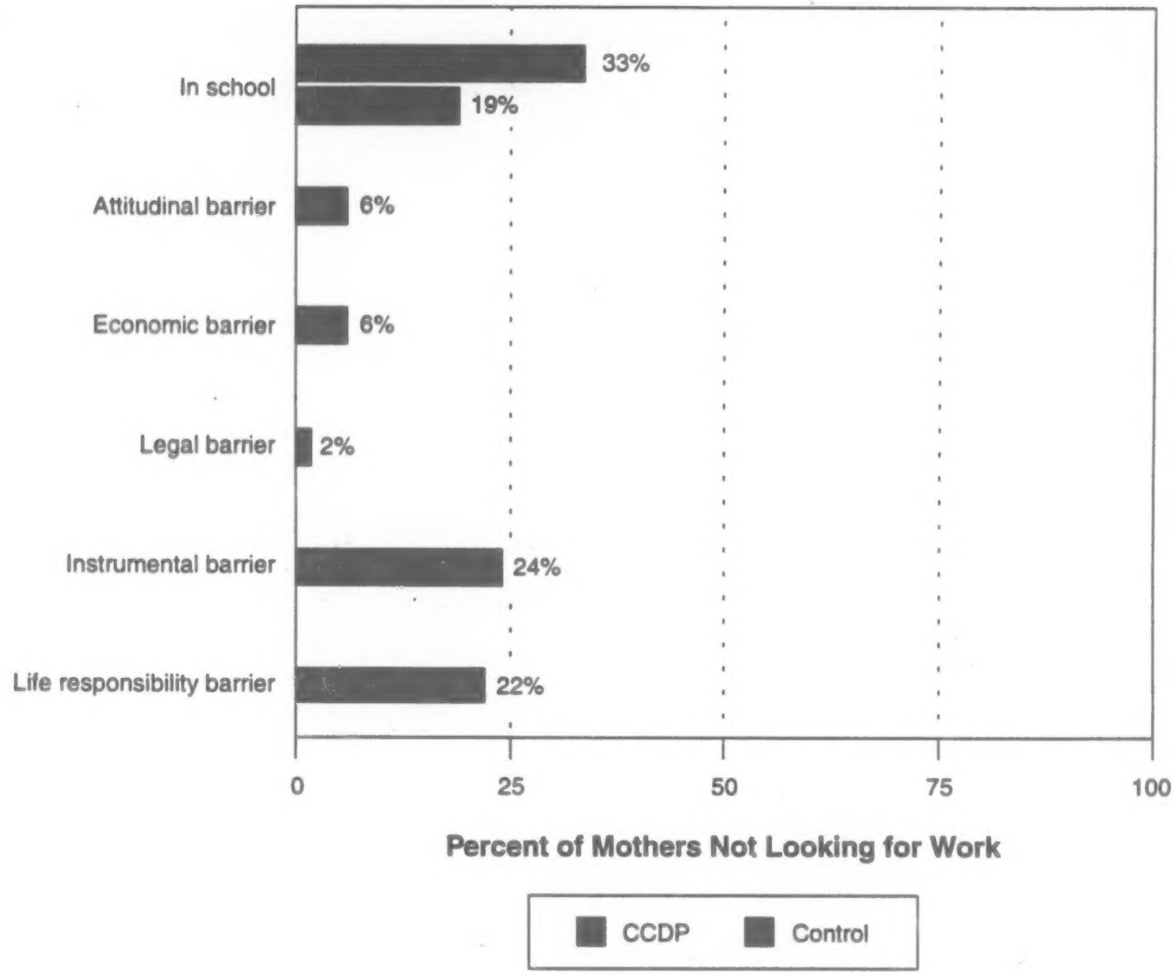
Summary of Effects on Mothers' Attitudes Toward Work*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

Exhibit 11-11

Summary of Effects on Mothers' Reasons for Not Looking for Work*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

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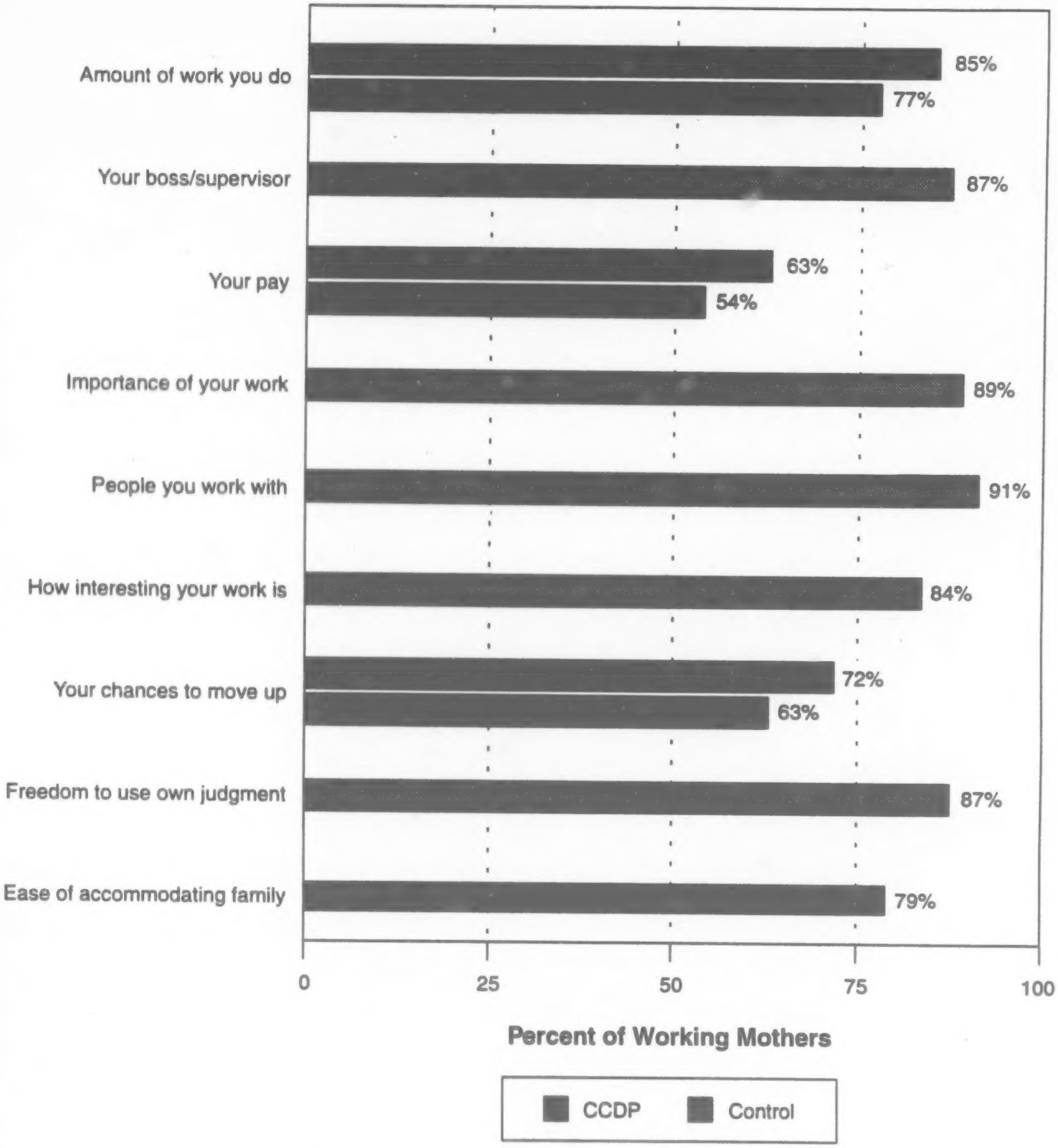
Exhibit 11-12

Summary of Effects on Mothers' Job Satisfaction*



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*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

(if any). As previously discussed, the CCDP mothers and their partners participated significantly more than their control group counterparts in educational activities. In addition, the CCDP participants reported a higher level of education achieved during the period of participation and more certificates/degrees in several areas than the control group participants.

The CCDP mothers reported a higher level of progress in the educational system than the control group mothers. During the past year, the CCDP mothers were significantly more likely than the control group mothers to have acquired a trade license or certificate (3.6 percent versus 2.7 percent), to have received an associate's degree (0.6 percent versus 0.3 percent), and to have completed a bachelor's degree (0.11 percent versus 0.05 percent). There was no CCDP impact on completion of high school or on receipt of a GED (general equivalency diploma).

All of these findings are consistent with the theory that, while CCDP has not had short-term effects on income and has increased participation in AFCD and food stamps, it also has increased enrollment in education and training programs and, ultimately, will lead to improved income and reduced government dependency.

CHILD/HOUSEHOLD STABILITY

This section discusses the measures used and the outcomes in the area of child/household stability.

Measures

One possible outcome of CCDP is that families' living situations may become more stable. This impact evaluation will assess changes in household membership over the duration of the program as well as changes in housing for the mother and focus child (including any periods of homelessness).

Effects on Child/Household Stability

A series of items about the focus child's living arrangements was used to assess the stability of the child's environment. One of CCDP's positive effects could be the facilitation of a reduction of the instability in children's lives, although there is no hypothesis that there would be large, immediate effects. Findings in this area are summarized in Exhibit 11-13 following the next page.

Each mother was asked questions about the child's living arrangements—specifically, which parents were in the household and whether the household was split, with some siblings living elsewhere. According to the mothers' responses, 97 percent of the focus children in the evaluation were living with their biological mothers at the time of the interview. The CCDP children were more likely than the control group children to have their biological fathers in the household (37 percent versus 35 percent) or to have either a biological father or other father figure in the household (42 percent versus 40 percent). In 8 percent of all families, a sibling was separated from the focus child and was living somewhere else (e.g., with grandparents, the father, other relatives, or friends); in 2 percent of the families a sibling was in a foster home; and in another 2 percent a sibling had died.

A composite was created from the above variables, to provide an overall indicator of the amount of stability in the focus child's environment. Participation in CCDP has made no difference in the stability/instability of a child's life, as measured by this overall index.

SOCIAL SUPPORTS/FAMILY PROBLEMS

This section discusses the measures used and the outcomes in the area of social supports/family problems.

Measures

One of the possible outcomes of CCDP is an increase in the amount of social support reported for the mother and family. The impact evaluation used items that assessed the amount of social support available to the mother and her satisfaction with that support.

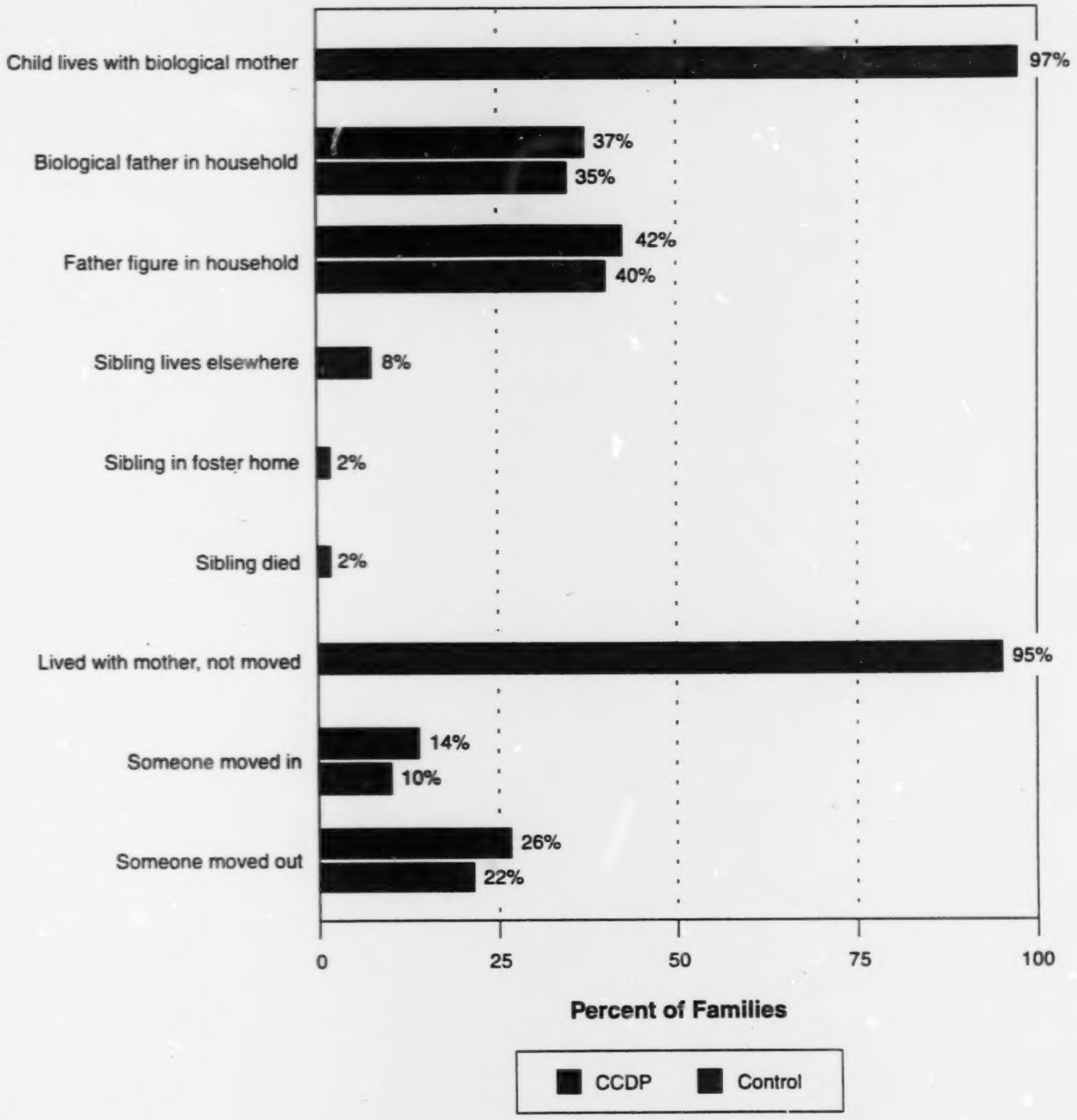
The evaluation also assessed the level of stress reported for the families, including major life events and chronic stresses. While major life events such as deaths of family members, have been shown to be significant stressors, research also has demonstrated the importance of "daily hassles" in the development of physical and mental health problems. The Difficult Life Circumstances Scale, developed as part of the NCATS study, was used for this purpose. This scale is a 28-binary-item interview measure that was developed to assess chronic, current family stressors, rather than stress resulting from significant life changes. The mothers also were asked a series of questions about their skills and resources in the areas of transportation, budgeting, support services, and support routines.

Effects on Social Supports/Family Problems

The Difficult Life Circumstances Scale (Barnard, 1988) asks a series of questions about family problems, such as "Is your partner in jail?"; "Do you have trouble with your landlord?"; "Do you or someone in your household have a long term illness?"; and "Do you have a problem with alcohol or drugs?" Because respondents did not have to answer all 28 items, the percentage of items that indicated a difficult life circumstance was computed for each mother. Thus, a mother's score could range from 0

Exhibit 11-13

Summary of Effects on Child/Household Stability*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

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percent (had no difficult life circumstances) to 100 percent (all questions identified a difficult life circumstance).

There were no differences between the responses of the CCDP and the control group mothers on the Difficult Life Circumstances Scale. On average, the mothers identified 16 percent of the questions on the scale as presenting a negative life circumstance.

QUALITY OF THE HOME ENVIRONMENT

This section discusses the measures used and the outcome in the area of quality of the home environment.

Measures

The HOME (Home Observation for Measurement of the Environment) instrument, developed by Caldwell and Bradley (1984) as a measure of the quality of cognitive stimulation and emotional support provided to the child by the family, was used to assess the home environment. HOME is intended to be completed based on observation of the home environment, with some open-ended interview items. This instrument was designed to sample certain quantitative and qualitative aspects of social, emotional, and cognitive support available to a young child in the home. Variables such as mother-child and father-child interactions, the emotional climate within the home, the physical home environment, and discipline techniques used in the home are included.

For assessments conducted at an office site or elsewhere outside the home, a survey version of HOME was used. The Home Screening Questionnaire (HSQ) (JFK Child Development Center, 1981) is a parent questionnaire, written at a third- or fourth-grade level, that consists of multiple choice, fill-in-the-blank, and yes/no questions; the questionnaire takes 15 to 20 minutes to complete. Psychometric studies show that HSQ is highly correlated with HOME total scores and that HSQ has adequate reliability.

Effects on Quality of the Home Environment

To assess the quality of the home environment, scores from HOME and HSQ were standardized and combined. The resulting analysis showed that there was no program/control group difference on the measure of the quality of the home environment, indicating that at this early point in the evaluation, CCDP has not measurably changed the home environment for participating children.

CHILD PHYSICAL HEALTH

This section discusses the measures used and the outcomes in the area of child physical health, including effects on overall health status, immunizations, injuries/accidents, health problems, dental case, and use of seatbelts.

Measures

A limited set of information on the children's health and growth was assessed through a variety of strategies. The mothers were asked to provide information on their children's overall health status; on immunizations; on the frequency of accidents, injuries, and hospitalizations in the prior year; on health problems; on dental care; and on the use of seatbelts (as seen in Exhibit 11-14 following this page).

Effects on Overall Health Status

The mothers were asked to rate the overall health status of their children. Eleven percent rated their children's health as fair or poor, whereas 89 percent rated their children's health as good or excellent. There was no difference between the program and control groups. While CCDP might be expected to lead to some improvement in children's overall reported health status, it is unlikely that large effects would be observed in this area, given that mothers in both groups rated their children's health so high.

Effects on Immunizations

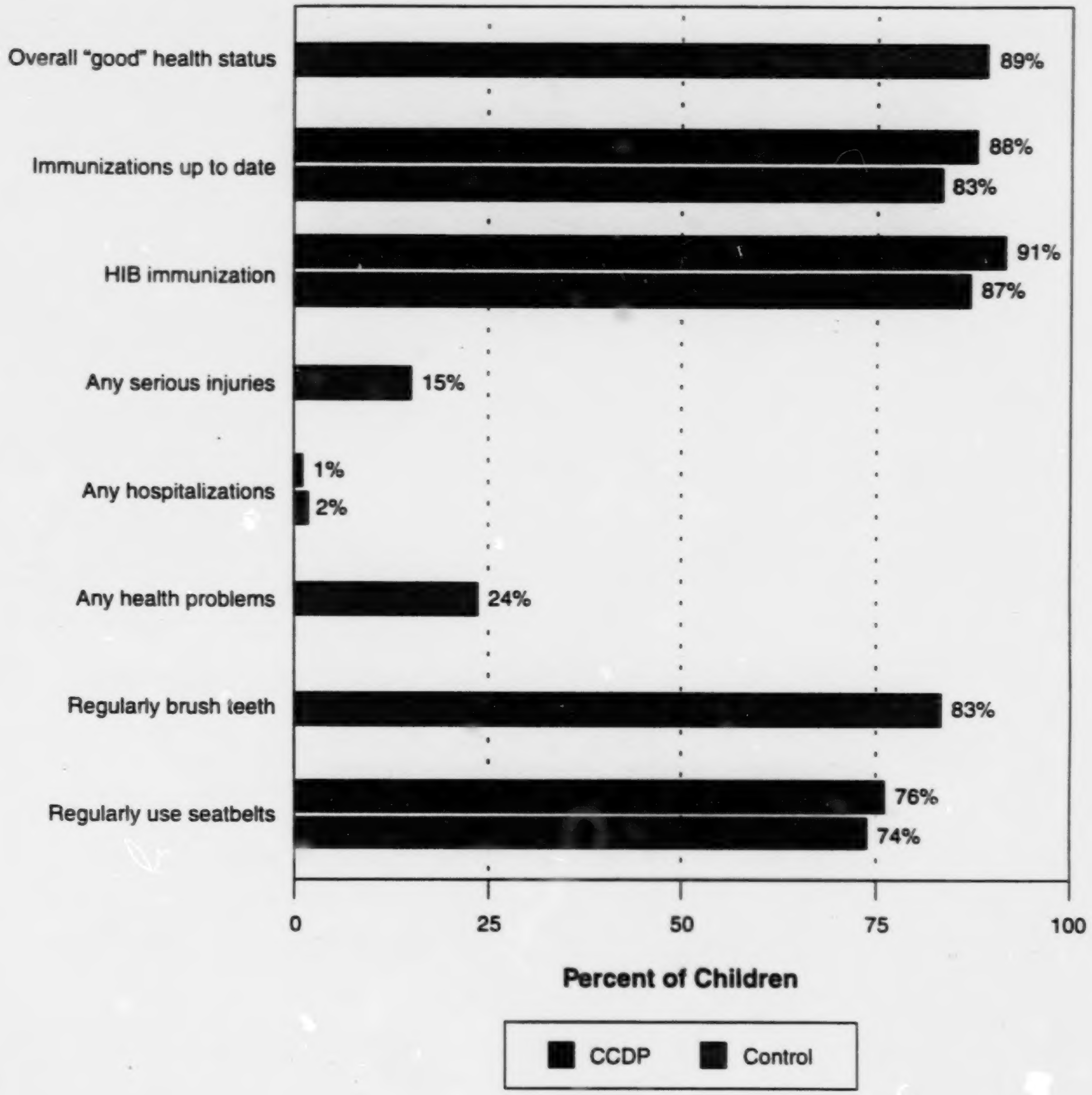
Exhibit 11-14 shows the results from two questions that were asked about immunizations. Significantly more CCDP mothers than control group mothers responded affirmatively when asked whether their children's immunizations were up to date (88 percent versus 83 percent). Furthermore, the children in CCDP were more likely to have had an Haemophilus influenza b immunization (91 percent versus 87 percent). These are extremely high immunization rates—so high that it is unclear whether the mothers were providing accurate recall data in this area.

Effects on Injuries/Accidents

A series of questions were asked about injuries and accidents that the child might have experienced. While there were no program/control group differences in terms of the number of serious injuries and accidents that occurred in the past year, the CCDP children were less likely to have been hospitalized for any injuries or accidents (1 percent versus 2 percent), and when they were hospitalized, they spent less time in the hospital.

Exhibit 11-14

Summary of Effects on Children's Health Outcomes*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

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Effects on Health Problems

The mothers were asked about their children's health problems. Twenty-four percent of the mothers (no difference between the program and the control groups) responded that their children had health problems of some sort.

Effects on Dental Care

CCDP did not appear to have any effect on dental care. Eighty-three percent of the mothers in the evaluation identified their child as a regular tooth brusher. On average, the children were said to brush daily.

Effects on Use of Seatbelts

When asked how often their children wore seatbelts, the CCDP mothers indicated more frequent usage than the mothers of the control group children: 76 percent of the CCDP children used seatbelts regularly, compared to 74 percent of the control group children.

CHILD COGNITIVE DEVELOPMENT

This section discusses the measures used and the outcomes in the area of child cognitive development.

Measures

The Bayley Scales of Infant Development (Bayley, 1969) were used to assess the cognitive development of the focus children from 12 through 24 months of age. The Bayley is the most commonly used assessment instrument in studies of infant development. It is a full-scale assessment measure consisting of a Mental Development Index and a Psychomotor Developmental Index (only the Mental Development Index was used in this evaluation). Administration of the Bayley Scales requires an average of 40 minutes for children in the 6- through 36-month age range. Items in the mental and motor scales cover a wide variety of tasks and behavior observable in the test setting and include a number of items reflecting adaptive social skills. For the current study, a revised version of the measure was used. The Bayley currently is being renormed.

Effects on Cognitive Development

The children participating in CCDP achieved an average score of 98 points on the Bayley Mental Development Index, compared to the average score of 96 points for the control group children. The 2-point difference corresponds to an effect size of 0.1 standard deviation units. This is a small but real effect of the program over the relatively short period of study.

While there was no expectation that CCDP would produce positive effects on children's cognitive development at this early point in the overall life of the intervention, the fact that a small, statistically significant effect was found provides promising evidence of the potential for long-term changes in children's cognitive functioning. How is one to judge the importance of this effect? Other recent research provides some clues.

First, there is ample evidence that intensive, child-focused, early childhood intervention can produce large effects on children's intellectual functioning. For example, the Infant Health and Development Program (IHDP, 1990) reported a 13-point (0.8 standard deviation units) effect on the Stanford-Binet for low-birthweight children who had participated in both a home visit program from birth to 12 months of age and a full-day, 5-days-per-week intensive child development program from 12 months to 36 months of age. This is a large and impressive effect on cognitive development resulting from an intervention that is much more intensive and child-focused than CCDP.

A related line of research on Project CARE (Wasik et al., 1990) investigated the relative effectiveness of the type of intensive, center-based, child-focused intervention undertaken by IHDP, as compared to a home-based intervention in which mothers were taught to provide proper child development activities for their children. As part of Project CARE, participating mothers received two to three visits per month for the first 3 years of their children's lives and one to two visits for the next 2 years. The home-based intervention was not found to have any effect on the intellectual functioning of participating children.

CCDP should be examined within the context of this existing research. Clearly, the full CCDP program is very different from either type of intervention discussed above. But from a child development point of view, CCDP probably is much closer to the Project CARE home visit model than the IHDP intensive center-based model. At least in the early years of a child's life, CCDP's approach is predominately one of using home visits rather than centers to provide child development services, and the results contained in this report are based on participation in CCDP from birth through age 2. Hence, the finding that CCDP produces a real but small effect on the Bayley for children who are 2 years of age is in line with what might be expected from existing research. The final report from this evaluation will present findings on children up to age 4 who have participated in CCDP. At that time it will be important to see whether the comprehensive range of CCDP services increases the size of the child-level effects already observed.

CHILD SOCIAL-EMOTIONAL DEVELOPMENT

This section discusses the measures used and the outcomes in the area of child social-emotional development, including effects on adoptive behavior and behavior problems.

Measures

The assessment of children's social-emotional development covered both adaptive behavior and behavior problems. The mothers were used as the primary respondents about the children's social-emotional development. Because acceptable direct measures of social-emotional development for infants and preschool children have proved difficult to use in large-scale studies, several major research studies have used checklists of adaptive and/or disruptive behaviors. Typically parents have been asked to report on the frequency of the occurrence of given behaviors. Although these measures have not been used extensively with non-English-speaking populations, the measures selected for this evaluation were translated into Spanish.

The adaptive behavior of the children in the evaluation sample was assessed with the Adaptive Behavior Inventory (Scott and Hogan, 1987). This scale is a 30-item parent report of children's social behavior, which takes approximately 10 minutes to administer. The items have been factor-analyzed into three scales and normed on an ethnically mixed sample of 36-month-old children participating in IHDP (IHDP, 1990). The original version of the instrument was in English, but the instrument's developers agreed to provide a Spanish translation for the CCDP evaluation.

Behavior problems were assessed with the Achenbach Child Behavior Checklist (Achenbach, 1984). The checklist has been used in multiple research studies and program evaluations. Most recently it was used as part of the test battery for the evaluation of the IHDP, and the measures showed significant program effects (IHDP, 1990). The Achenbach Child Behavior Checklist has two versions—one for children (ages 2 to 3 and one for children ages 4 to 16. The checklist for children ages 2 to 3 consists of 99 items describing behavioral/emotional problems that parents and parent surrogates can report with a minimum of inference. Parents read the items or the items are read to parents, who respond in a yes/no format. Space is also provided for writing in additional problems that are not specifically listed. The measure is fairly quick and easy to administer.

In addition to the battery of child-rating scales, the assessment of social-emotional development included survey items on whether or not the child had received treatment for emotional or psychological problems.

Effects on Adaptive Behavior

The Scott and Hogan Adaptive Behavior Inventory contains three subscales describing aspects of social behavior, including expressive behavior (e.g., follows rules in games, waits his/her turn, and cooperates with requests), socially competent behavior (e.g., understands others' feelings, is open and direct about wants, and says friendly things to others), and disruptive behavior (e.g., is bossy, disobedient, or not helpful). There were no program/control group differences on any of the three subscales. However, two of the subscales expressive behavior and socially competent behavior often are combined to form a total score for "prosocial behavior." Using this combined scale, CCDP children were rated as exhibiting significantly more prosocial behaviors than control group children.

Effects on Behavior Problems

The Achenbach Child Behavior Checklist was used to obtain maternal reports of behavior problems in CCDP children and in control group children. The checklist asks a series of questions about behavior problems. From the responses, six subscales are formed, including social withdrawal (e.g., acts too young, does not eat well, and refuses active games), depression (e.g., is moody, withdrawn, or disturbed by change), sleep problems (e.g., has nightmares, cannot sleep, or resists bed), somatic problems (e.g., has aches, nausea, or rashes), aggression (e.g., is defiant, screams, or hits), and destructiveness (e.g., is cruel to animals, holds breath, destroys own things). Two scores can be calculated for each scale: (1) a simple count of the number of problems and (2) whether the child reaches a level considered abnormal for the scale.

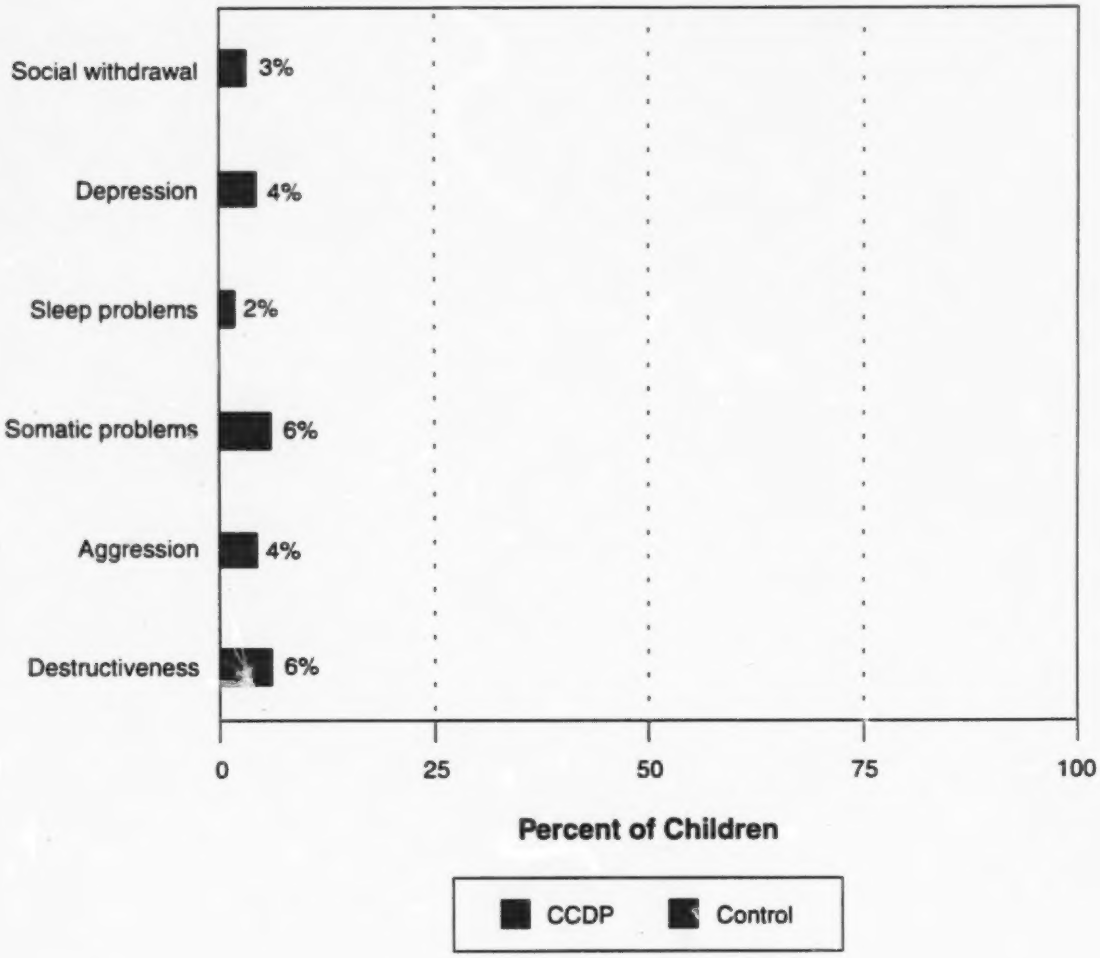
There was no program/control group difference on any of the scales in terms of the percentage of children rated "abnormal." Similarly, there were no effects of CCDP on any of the behavior problems measured by the Achenbach Child Behavior Checklist. Exhibit 11-15 following this page shows that small percentages of children (between 2 and 6 percent) were scored as having abnormal behavior on each of the six scales; therefore, it would be difficult for CCDP to have large effects in this area.

DIFFERENTIAL IMPACTS FOR SUBGROUPS

Each outcome variable reported on in this chapter was reanalyzed to determine whether CCDP was differentially effective with certain subgroups. Variation in effects was investigated for four grouping variables:
(1) whether the mother was a teenager at the birth of the focus child,
(2) whether the mother was single at the birth of the focus child,
(3) whether the mother had completed high school, and (4) whether the child was a male or female.

Exhibit 11-15

Summary of Effects on Child Behavior Problems*



*Two bars indicate a statistically significant effect; one bar means there is no CCDP/control difference.

The subgroup analyses were conducted for each of the 150 separate outcome variables used in the main analyses. Only 8 of more than 500 separate analyses (150 outcome variables * 4 grouping variables) showed significantly different impacts between subgroups at the $p<0.01$ level. This small number of significant differences could have occurred by chance alone, and at this preliminary stage in the analysis, CCDP does not appear to be differentially effective with the subsets of families included in these analyses. No positive or negative value is attached to this finding, since there are no special hypotheses about CCDP's effectiveness with subgroups of families.

There is a reason why differential impacts might be expected across subgroups: Teen mothers, single mothers, and mothers who did not complete high school may well be more difficult to involve in the CCDP program than older mothers, mothers who live with a partner, and mothers who have a high school education. If this is the case, then CCDP might do better with the easier-to-reach group or, conversely, do less well with the difficult-to-reach group.

No evidence was found to support this hypothesis. Rather, it appears that CCDP's effects are about the same for teen mothers and for older mothers, for single mothers and for mothers living with a partner, and for mothers who did not graduate from high school and for mothers who are high school graduates.

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PART IV. SUMMARY AND CONCLUSIONS

Chapter 12. Summary and Conclusions

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The results presented in this report suggest that after approximately 3 years of serving families, Comprehensive Child Development Program (CCDP) projects are displaying their potential for helping families take positive steps toward achieving their goals. Comments provided by advisory board members also suggest that CCDP projects may have positive diffusion effects on their communities and, by implication, that non-CCDP families living in these communities also may be benefiting from the presence of CCDP. In this final chapter, a brief summary of the philosophy of CCDP is presented in order to provide the context for understanding the "CCDP model" in terms of its underlying set of theories about family and individual development. This is followed by a summary of the major feasibility analysis, process evaluation, and impact evaluation findings organized according to the policy questions they address. Tentative conclusions regarding these findings also are presented. In the final report, a wider range of policy questions will be addressed by analyses that will yield more definitive answers regarding CCDP's goals.

PHILOSOPHY OF CCDP

The Comprehensive Child Development Act of 1988 was enacted because of the growing recognition that low-income families are becoming increasingly vulnerable in today's society and that human services need to reach these families early enough to be sufficiently comprehensive and sustaining over an adequate period of time to make real and meaningful differences in family members' lives.

Human services systems for these families have been criticized historically as categorical, fragmented, and even somewhat disorganized. The focus of these systems has been on achieving singular objectives and serving the needs of some, but not all, family members. Furthermore, the existing public welfare system has been overburdened by severe staff shortages, inadequate resources, and little or no interagency coordination or service integration, making it difficult for family members to access the services that are available. The need to examine an alternative approach to traditional human service delivery has never been more apparent or timely. CCDP has been identified as such an alternative approach.

Conceptually, CCDP embodies the values and ideals of the family support community. Specifically, CCDP does the following:

- Involves the whole family and the whole community in program planning and implementation;

- Establishes a system of networks characterized by peer and staff supports;
- Focuses on optimizing child growth and preparing children for later school experiences;
- Prepares parents as significant change agents in their children's development and in their own development;
- Serves as a catalyst for connecting various community and public programs and agencies that deliver specific services;
- Builds upon each family's strengths rather than serving only as a remedy for weaknesses;
- Intervenes early in the life of a child and family and provides continual support over a sustained period of time; and
- Assists families in meeting goals by working with them to establish relevant and viable paths and roadmaps for progressing along these paths.

SUMMARY RESPONSES TO STUDY POLICY QUESTIONS

Below are presented preliminary findings and conclusions in response to each of the five broad policy questions identified in Chapter 1 of this report.

***Question 1:** Are the families enrolled in CCDP those who can benefit the most from a comprehensive, integrated program like CCDP?*

The legislation authorizing CCDP reflects the congressional mandate that CCDP projects address the needs and goals of multiple-risk, low-income families throughout the United States. Data presented in this interim report indicate that CCDP projects have achieved this goal. All 3,300 families enrolled in CCDP as of March 31, 1993, met the income eligibility guidelines set out in the Comprehensive Child Development Act. Eighty-five percent of these families live in urban areas, some in the poorest inner-city sections in the country, and the remainder live in rural areas beset by a host of social and economic problems. At least 1 project is located in each of the 10 Department of Health and Human Services regions. The racial composition of the CCDP families is as follows: African-Americans (45 percent), Hispanics (27 percent), whites (25 percent), and a small percentage of other racial groups (approximately 3 percent) including Asians and Native Americans. Only 31 percent of the CCDP families' households have an adult male present.

An important fact concerning CCDP is that, unlike traditional social service programs that serve only one or two family members (typically a mother and her children), all family members are served by CCDP. Since its inception in October 1989, CCDP has served 14,485 individual family members including mothers, fathers, children, and other relatives (such as grandmothers, aunts, uncles, and cousins).

Analyses indicate that a majority of the CCDP families had received some sort of social or welfare service prior to enrolling in CCDP. Furthermore, families being served by CCDP have a wide range of stated needs and goals. For example, more than one-half of the families that ever enrolled in CCDP identified a need or goal related to basic necessities including housing (66 percent), child care (62 percent), transportation (58 percent), and health care (58 percent).

Even more families identified needs or goals that relate to reaching beyond a minimal standard of living toward becoming socially and economically self-sufficient, including improved parenting skills (94 percent), improved access to community resources (93 percent), and increased income (86 percent). CCDP families also desire the following: greater educational attainment; vocational and job training; alcohol/drug and mental health counseling and treatment; basic living skills; home management training; and improved physical, social, and cognitive child development. As discussed in this report, CCDP projects have been very successful in addressing the families' needs and goals.

It is important to understand that CCDP is designed to serve many different types of families. While providing intensive interventions for families that suffer long-term crises, CCDP also is designed to work with families that are able and motivated to work actively toward economic and social self-sufficiency. CCDP is a program that focuses first and last on helping families achieve whatever goals are important to them.

***Question 2:** Was CCDP implemented as intended by the authorizing legislation? Did families receive and utilize available services?*

Preliminary results regarding program lifecycles, core services, case management, interagency agreements, and service receipt and utilization are discussed below in connection with this question.

Program Lifecycles

The design and implementation of a comprehensive program addressing the mandates of Congress and the needs of low-income families and communities presented many challenges and problems for grantees. For example, there was no model available to provide guidance to grantees regarding the optimal staffing of CCDP projects; therefore, most projects had to make adjustments to their staffing plans and organizational structures subsequent to enrolling their full complement of families. Furthermore, few models existed to help grantees create systems of integrated and comprehensive services for families with wide ranges of needs and goals. Therefore, it is not surprising that CCDP projects took up to 2 years to begin becoming stabilized organizations.

Stabilization was evidenced by the formulation of organizational procedures, policies, and goals; staff who understood and followed organizational rules and procedures; the existence of a range of services designed to meet the families' needs; the development of stable interagency relationships; and an organizational focus on quality control and responsible long-term fiscal management. An important finding regarding the development of CCDP projects is that, by the end of calendar year 1992, all but one project was at least stabilized and some projects appeared to be entering the institutionalization phase. Probably the most important factor associated with a smooth and relatively quick transition to the stabilization phase was the relatively few number of changes in individual projects' goals and philosophies. Projects that made changes in their goals and philosophies tended not to advance as far along in their organizational development. In turn, changes in goals and philosophy appeared to be related to the way in which project staff approached families in crisis. In projects where staff perseverated on crisis intervention to the neglect of the enhancement of family strengths and goal identification, project directors found it necessary to take steps to refocus their staffs' efforts from utilizing traditional social work techniques toward incorporating techniques to help the families help themselves in reaching their goals.

Core Services

Preliminary results indicate that all 21 projects examined in this report provided or made available to families core services mandated by the Comprehensive Child Development Act. More importantly, CCDP staff have developed a variety of creative programs and strategies tailored to serve the unique needs and goals of families in their communities. For example, many CCDP projects initially underestimated families' need for child care and the attendant problems coordinating and financing child care services. In response, projects have (1) enlisted local families to volunteer to provide short-term day care in their homes; (2) provided monetary and technical assistance to parents interested in becoming full-time, licensed family child care providers; or (3) employed the services of a child care consultant to develop practical arrangements for the care of young children. CCDP projects also have applied for local grants earmarked for improved local child care, negotiated arrangements with local departments of education to provide school-based child care, purchased large numbers of child care slots at lower than normal rates, or renovated CCDP sites to include full-time or drop-in day care centers. Currently nearly one-half of the CCDP projects operate their own child care centers, which can be used by parents who work, go to school, or participate in project activities. An indicator of the success that CCDP projects have had providing affordable child care is the fact that only two projects reported having insufficient numbers of child care slots in their service areas.

Another example of CCDP projects' endeavors to help families meet their needs involves their efforts to address families' health care needs. Each project has developed a model for health care delivery that makes the following services available to families: prenatal, well-baby, and acute care; health screening and assessment; immunizations; and preventive care. The models that have been developed by the project vary widely. Some models rely more on formal or referral agreements with clinics or medical centers to provide routine health care, whereas others provide health care on site. More than one-half of the projects have established linkages with private providers to maintain continuity of care for families that had established relationships with providers before enrolling in CCDP. Furthermore, four of the five rural CCDP projects provide health services during home visits to avoid having to provide long-distance transportation to families in need of health services.

As noted previously, CCDP projects are not expected to provide all core services directly. Instead, CCDP projects utilize two basic mechanisms to ensure that all families have access to needed services: (1) case management and (2) interagency agreements. Each of these mechanisms is discussed below.

Case Management

Case management plays a central role in the CCDP model. Case management entails placing responsibility for service planning and delivery and systems coordination with a person or team who works with the family in an intensive, continuing relationship in order to accomplish the following:

- Develop and identify family needs and goals;
- Develop an appropriate service plan;
- Ensure access to services;
- Monitor service delivery; and
- Monitor service outcomes and goal attainment.

Case management models used by CCDP grantees are based on a family support model that emphasizes the concept of family empowerment, which is reflected in CCDP projects' emphasis on actively engaging families in the case management process. Thus far it appears as though the most utilized case management model is the generalist model, in which individual case managers (who have an average caseload of 13 families) provide case management services in addition to early childhood education and parent education during home visits. Among the projects that use a team approach to case management, the prime virtue of the team model—having several specialists work together with a family—also poses its greatest potential weakness insofar as the lines of responsibility and reporting often become blurred.

Regardless of the model used, it appears that CCDP projects have been successful in providing case management services. Results indicate that 99 percent of the CCDP families received case management services during the first half of Fiscal Year (FY) 1993, with an average of two case management services provided to each family per week. Furthermore, data presented in this report indicate that CCDP projects have experienced success in their attempts to provide services to meet the needs identified by families during the course of the case management process. In only two categories of needs—clothing and home management skills—did fewer than 100 percent of families receive or utilize at least one type of service in connection with their needs, and frequently more than one different type of service was provided to address families' needs. Together with results of analyses of individual family members (which followed similar patterns), the data reflect the case managers' resourcefulness and responsiveness in targeting different types of services to the problems faced by families.

Interagency Agreements

The second mechanism used by all grantees to ensure families' access to needed services involves the creation of interagency agreements. Interagency agreements between CCDP and other community agencies are necessary because grantees are not funded to provide directly all services needed by families. Preliminary findings suggest that such agreements have aided cooperating agencies in establishing common definitions, including definitions of the population to be served, and have led to a better understanding of what agencies can expect from one another, thus avoiding the turf battles that often arose when a CCDP project first entered the community. Interagency agreements also have helped cooperating agency staff members learn more about available services and how to access them and have greatly facilitated the linkage of families with service providers. Interagency agreements also can serve as a mechanism to effect systemic changes in the community services network.

By March 31, 1993, CCDP projects had established more than 3,000 interagency agreements. Three-fourths of these agreements involved long-term arrangements with major community agencies, while the remaining agreements typically involved short-term agreements with providers that offer individualized services.

Services Utilization

A primary indicator of the successful implementation of CCDP is the degree to which families receive or utilize needed services. The preliminary results of service receipt and utilization data covering the first half of FY 1993 indicate that CCDP clearly has helped families and family members utilize program and community resources to secure routine and preventive health care, improved housing, nutrition assistance, adult education, and a number of case management services. For example, within the category of "active services" (meaning that individual initiative is called for to access and utilize these services on an as-needed basis), 78 percent of all families utilized health services approximately once per month, 71 percent of the families utilized adult education services approximately once per month, 70 percent of pregnant women received a prenatal care service approximately once per month, 57 percent of families utilized nutritional assistance services approximately twice every 3 months, and 57 percent of all families received material or financial assistance approximately twice every 3 months.

Results of analyses of "receptive services" (i.e., services provided directly by the CCDP project and which all participating families receive) indicate the following:

- 99 percent of all families received at least one case management service, and on average, each family received eight case management services per month;[1]
- 80 percent of families received parenting education services approximately once every 2 weeks;
- 75 percent of children under age 5 received developmental screenings or assessments approximately once every 3 months; and
- 2,743 preschool-aged children (who were members of 1,614 families) received early childhood education in the home, and these children on average received such education more than once every 2 weeks.

In the 2½ years that CCDP has served families, CCDP projects have observed the multitude of needs of low-income families, many of whom are covered by CCDP core services and some of whom are not. In response to family needs beyond core services, CCDP projects have moved beyond the congressional mandate and made available a number of noncore services. These services are needed to fill service gaps in the community, connect otherwise isolated families to their communities, and provide parents with additional opportunities to participate in critically important decisions regarding their futures. The noncore services provided by projects include programs for teen parents, recreation and socialization opportunities, legal assistance, emergency assistance, loan funds, parent advisory councils, volunteer programs, and opportunities for advocacy and participant feedback.

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[1] The large difference between this percentage and the 58 percent figure in the impact study may be explained by several factors: As already noted, the process study sample included only currently active families, virtually all of whom were receiving case management services, while the impact study sample included many families who had left the program. Also, process study data were contemporaneous records made by staff, whereas impact study data were parent reports based on recall over a 1-year period. Parents may have failed to recall some meetings with their case managers or may not have defined some contacts as "meetings."

***Question 3a:** How have families benefited from CCDP? Are families satisfied with CCDP?*

CCDP is designed to provide intensive, comprehensive, integrated, and continuous support services to low-income families with children. Important accomplishments of the program include achieving (1) family and individual goals designed to satisfy basic needs (e.g., deficit reduction), (2) goals designed to enhance family development (e.g., empowerment), and (3) family satisfaction with available services and services received. Below, results regarding goal attainment and family satisfaction, which address these broad types of accomplishments, are discussed.

Goal Attainment

Deficit reduction goals identified by more than one-half of CCDP families include housing (69 percent), child care (65 percent), transportation (58 percent), and health care (57 percent). An indicator of the success that CCDP projects have had in assisting families overcome their problems in these areas is the fact that more than 80 percent of the families have either achieved these goals or made progress toward achieving them.

A number of families set several important goals related to empowerment, including improved parenting skills (67 percent), improved access to community resources (47 percent), and increased income (48 percent). Among the families that identified these as goals, a large majority either made progress toward or achieved their goal of using community resources (93 percent), improving their parenting skills (94 percent), and increasing their income (86 percent). This suggests that families currently are involved in vocational training, are improving their education, or are actually employed. This reflects significant family accomplishments at this fairly early stage of CCDP enrollment.

Preliminary findings indicate that between 80 and 95 percent of family members made progress or achieved the deficit reduction goals they set in areas such as health and nutrition, mental health, literacy, relationship skills, and housing. More than 80 percent of the family members reported having made progress or having achieved their goals related to empowerment. These goals include furthering one's education; earning a sufficient income; developing parenting skills; enhancing the physical, social, and cognitive development of the child; obtaining child care; developing home management skills; obtaining employment; and acquiring self-sufficiency.

It is important that these preliminary results be interpreted in relation to the fact that the families have been enrolled in CCDP for an average of only 25 months and that families were not expected to have attained many of these goals (e.g., obtaining a good paying job) at this early stage in their enrollment. The reason for this is that families usually set multiple, interrelated goals, and some goals must be achieved first before others can be achieved. This is illustrated by the finding that many family members do not have a high school diploma, do not speak English as a first language (if at all), and come from homes where welfare dependency has been a reality over several generations.

Family Satisfaction

Assessing family satisfaction with CCDP is critical because this offers insight as to how and why a family utilized, or did not utilize, program services. In general, CCDP participants expressed satisfaction with the program and its components. Ethnographers noted that families most involved in CCDP were the most satisfied with their experiences in CCDP. For example, one ethnographer found that parents who indicated a great deal of satisfaction with the program were those who had fully participated in the program. Ethnographers also noted that (1) many CCDP families relied on their case managers and other parents to help them become more involved in CCDP program activities and (2) families depended on those personal relationships in order to remain optimistic about their families' long-term outcomes.

Judging by the overall level of satisfaction expressed by families, CCDP projects appear to have been successful in addressing CCDP families' needs and goals. However, despite this overall support, families felt that several areas need improvement. First, families suggested that projects should provide more comprehensive child care services with extended hours during evenings and weekends. Second, families would like to have access to more individually tailored parenting and job training programs. Third, families felt that their relationships with project staff and other families needed to be more consistent and that the quality of communication among staff and families could be improved. Many of these recommendations have or will be implemented soon.

In the early phases of the program, CCDP staff spent much of their time, energy, and resources on a small number of families experiencing multiple intractable crises. While CCDP staff made efforts to assist these families, several were terminated from the program due to nonparticipation or inappropriate behavior. In fact, about one-third of the families that have been terminated from CCDP thus far have been terminated for these reasons. The other two-thirds of families that have been terminated have left voluntarily: one-third for reasons interpreted as reflecting a positive change attributable to participation in CCDP, and the other one-third due to problems associated with alcohol and other drug use or domestic violence.

Analyses of rates of termination over time revealed that there appears to be a decline in the proportion of families that stay enrolled in CCDP for less than 1 year and that, overall, terminations have decreased among both original and replacement families. Although more data are needed, the trends suggest that as projects stabilize, they (1) address families problems more effectively and (2) increasingly enroll families most in need of the types of services offered by CCDP. In the final report, this hypothesis will be confirmed or refuted, and findings will be related to costs.

Question 3b: What impact does CCDP have on parents and children?

After 2 years of program operation, it is clear that families participating in CCDP receive more social, educational, and health services than families who do not participate. This difference in utilization of services is an important first step for CCDP in its attempt to produce long-term positive changes in the lives of participating parents and children.

Furthermore, after 2 years of program operation, this study found many small but important statistically significant effects of CCDP on parents and children. These short-term effects are in line with expectations about the program, and it will be important to look for larger effects as families continue to participate in CCDP. Major findings from the impact study are summarized below.

- *Maternal physical health.*—Mothers who participated in CCDP and who had a subsequent pregnancy, compared to their counterparts in the control group, had delayed the pregnancy longer (an average of 26 days), had used alcohol less, had heavier babies (7.2 pounds versus 7.0 pounds), and had babies who spent fewer nights in the hospital (3.6 versus 5.0 nights) and who were less likely to require special care (11 percent versus 15 percent).

- *Child physical health.*—Compared with children in the control group, CCDP children had fewer hospitalizations for injuries (1 percent versus 2 percent), spent less time in the hospital when they were injured, and used seat belts more regularly (76 percent versus 74 percent). Also, children participating in CCDP were more likely to have seen a doctor for preventive health care (87 percent versus 84 percent).

- *Parenting attitudes.*—CCDP mothers were less likely than control group mothers to report attitudes toward parenting and expectations of children that, in past research, have been linked to abusive and neglectful behaviors.

- *Parental expectations.*—CCDP mothers reported higher expectations of children's school success than control group mothers.

- *Parent involvement.*—CCDP mothers reported spending significantly more time with their child than did control group mothers. Also, mothers reported that resident fathers in CCDP families spent more time looking after their child and more time in daily activities with the child than fathers in control group families.

- *Parent-child interactions.*—In observations of mothers' interactions with their children, CCDP mothers were more sensitive than control group mothers to cues given by the child, responded more appropriately to signals of distress on the part of the child, and were more likely to behave in ways that foster social-emotional growth in a child.

- *Economic self-sufficiency services.*—CCDP mothers were more likely than control group mothers to have been enrolled in academic classes (38 percent versus 2[illegible] percent) and vocational/job training classes (18 percent versus 13 percent) and were more likely to be working toward a trade certificate (7 percent versus 4 percent), a GED (general equivalency diploma) (12 percent versus 8 percent), or a bachelor's degree (6 percent versus 3 percent), all of which are designed to facilitate economic self-sufficiency.

- *Economic self-sufficiency outcomes.*—There were no differences between CCDP and control group mothers in terms of employment or income levels.

- *Job satisfaction.*—CCDP mothers who were working reported greater satisfaction than control group mothers with the amount of work they were doing (85 percent versus 77 percent), their pay (63 percent versus 54 percent), and with their chances of "moving up" (72 percent versus 63 percent).

- *Child development.*—Children in CCDP scored higher than control group children on the Bayley Scales of Infant Development and exhibited more prosocial behaviors (e.g., were cooperative and followed rules) than control group children. Though statistically significant, the effect on the Bayley is small in absolute terms (a two-point difference). This is not unexpected given that other early childhood interventions work much more intensively (e.g., 5 days per week) with children. Thus, it will be important to test CCDP children at ages 3, 4, and 5 in order to determine whether the observed effects on cognitive development continue to grow.

What conclusions can be drawn from these findings? First, CCDP has put mothers on the road to improved economic stability. The evidence for this is that CCDP mothers participated more than control group mothers in a wide range of educational services (e.g., academic classes, job/vocational training classes, and GED classes), which in the long run should increase their economic chances. Further, CCDP mothers who are working report greater satisfaction with their jobs than do control group mothers. There is not yet any evidence that mothers' incomes or employment statuses have been improved by CCDP, but participating mothers are engaging in vocational training or educational activities that ought to lead to these outcomes.

A second conclusion drawn from this study is that CCDP has reduced several elements of risk for participating children by improving their home environments. This has been accomplished in many ways—by improving the health of infants born to CCDP mothers, by reducing mothers' attitudes shown to be associated with child abuse and neglect, by increasing mothers' expectations for their children's school success, by increasing the amount of time that mothers and fathers spend with their children, and by teaching mothers to interact more positively with their children. These risk-reducing factors all are important steps toward CCDP's goal of improving long-term chances for participating children.

As a family support program, CCDP relies heavily on intervention with parents to influence their children's early development, rather than on direct programmatic intervention with children between birth and age two. And, as seen above, CCDP is moving in the right direction by reducing risks for children in many areas. It will be important to determine whether CCDP's small but important effects on child development grow in future years as children near school age.

Question 4: *What impact has CCDP had on the community?*

In addition to affecting individuals and families, CCDP projects also affect communities. CCDP projects have been implemented in a variety of community contexts. Some of the community contexts include previously established service networks, whereas other communities have no history of services coordination or cooperation. Coordinated service networks, found in nine of the communities, occurred where service coordination had a longer history, borne of necessity and efficiency (particularly in rural areas). Uncoordinated service networks, on the other hand, were characterized by agency relationships described as ad hoc and informal. These were reflected in fragmentation of services and conflicts between public and private agencies. In these communities, "turf" battles interfered with efforts to develop a coordinated service network. These turf issues most frequently involved funding priorities and service boundaries set by agencies awarding the funds. In the uncoordinated service networks examined, money, accountability, and service coordination rarely extended beyond the confines of a single institution. Despite the fact that some CCDP projects were implemented in this type of environment, once the potential of the CCDP projects was realized, many agency personnel enthusiastically embraced the goals and philosophy of CCDP. The concrete result, as reported by CCDP advisory boards, project directors, and ethnographers, is that CCDP projects have facilitated services integration at both the service and systems levels.

Ten of twelve ethnographers reported such information and identified improved coordination in their communities.

One of the most important changes in the relationships among service agencies since the implementation of CCDP has been the fact that directors of the major community agencies are working together—along with employment and training agencies, human services agencies, health care agencies, and various private, not-for-profit providers—to take actions designed to better serve low-income families. Changes that have occurred in the service networks since the inception of CCDP include development of new linkages and strengthening of old linkages, increased interagency awareness and understanding, and more frequent interagency case management staffings.

Three major themes are evident regarding community impact; these themes have been drawn from a triangulation of three data sources—ethnographer reports, CCDP advisory boards, and CCDP project directors.

The first major theme is that CCDP projects have had an impact on community service networks. This impact was observed at the systems level (e.g., through changes in eligibility requirements or eligibility waivers), but most frequently at the service delivery level (e.g., through interagency cross-training, coordination of case management functions, development of resource data bases, development of new services, and reduction in duplication of services).

The second major theme is that CCDP projects have had an impact on their grantee agencies. As grantee agencies learned more about the nature and needs of CCDP projects and families, adjustments were made to their own organizations to better adapt to the needs of the community and its families—needs of which they may not have been previously aware. Grantee agencies also learned to be more sensitive to particular populations that the agencies had not previously served but were targeted by CCDP projects. In other cases, grantee agencies expanded their funding bases through collaborative efforts with CCDP projects to tap alternative funding streams.

The third major theme is that CCDP projects have had an impact on families. An increased range of services was made available to both CCDP and non-CCDP families. Some of these services were already available in the communities, but in other cases the CCDP projects facilitated accessibility to services or created new services that were available for all families in the communities that were in need. Examples of the diffusion of new services in the communities as the result of CCDP projects' efforts include child care, adult education, and parenting education. These communitywide diffusion effects will be examined in more detail in the final report. In particular, the analysis of the cost-effectiveness of CCDP will consider these potential diffusion effects relative to the direct cost of CCDP.

Question 5: What are the costs of CCDP?

The cost findings indicate that the average annual Federal nonresearch cost per family is $8,243. Because CCDP serves all family members, the average annual Federal nonresearch cost per family member is $2,137.

There is a fair degree of variability in costs across projects, with annual per family costs ranging from $4,592 to $13,413 and annual per family member costs ranging from $1,140 to $4,023. Preliminary findings suggest that these variations are due to differences in child care supply and demand, transportation, and population density. In the final report, costs per service component will be reported in order to identify areas where costs may be cut without undermining the essence of the CCDP model.

APPENDIX A

SAMPLE CASE MANAGEMENT GOAL AND ACTION PLAN

Page 1 of :

Case Management: Goal and Action Plan

Date ____ Family ID# ____ Advocate ____ Specialist Approva

County ____ Site ____ Family Name

GOAL #1 HOUSING: Whose Goal? ________ Joint (J), Primary Caregiver (PC), Advocate (A)

Primary Effect: _____ Family _____ PC _____ Focus Child _____ Sibling _____ Other (List) ____________

STATUS OF GOAL AREA AND BARRIERS TO MEETING THE GOAL:

STRATEGIES / ACTION PLAN

Actions Planned: By Whom, How Long, By When (number strategies to reach goal)	Date Approved	Date Accomplis

GOAL #2 INCOME SUPPORTS: Whose Goal? ________ Joint (J), Primary Caregiver (PC), Advocate (A)

Primary Effect: _____ Family _____ PC _____ Focus Child _____ Sibling _____ Other (List) ____________

STATUS OF GOAL AREA AND BARRIERS TO MEETING THE GOAL:

STRATEGIES / ACTION PLAN

Actions Planned: By Whom, How Long, By When (number strategies to reach goal)	Date Approved	Date Accomplish

Community-Family Partnership
FBSP Goal Development

the documentation of the work plans for resolving problems identified by families.

First & Last Name	Family ID#	Staff	Date	Revision #	Type

MIS Need Label	Need-Label #	MIS Goal Label	Goal-Label #	Assess.

NEED or problem faced by family:

Need - derived from needs assessment information. Needs may be written in the family's language. Include sufficient narrative material so that the problem is described clearly and with sufficient detail so that any reader has clear understanding of the need or problem faced by the family/family member.

Translate this need into a GOAL: Goal - the destination or outcome that will be achieved when the need or problem is resolved. Goals must be clearly understandable, measurable, and have a time frame. Goals are written to reflect what the family/family member really wants to have happen if the goal is attained. Example:

1) Mary will improve her reading grades. (poor)
2) Mary will receive a score at or above the 50th percentile on school administered reading achievement testing administered in April, 1991. (improved - but is this the family goal)
3) Mary will earn a "B" grade in reading on her report card during the final grading period of this school year. (Family Goal)

Family ID#	Need #	Goal #	OBJECTIVES	# Completed	# Revised	# Deleted

We'll know this goal is accomplished when the following OUTCOMES can be seen:	Start Date	End Date

Objectives are the measures along the journey to goal attainment that help the family and family consultant judge if the family is making progress towards a goal. Objectives are observable or measurable outcomes. Some objectives are sequential in that attainment of one objective is necessary before sufficient skill is present to attain the next objective. Other objectives may be attained simultaneously. It is usually necessary to achieve most objectives if the goal is to be accomplished. Objectives, like goals, must be clear, measurable, and have a time frame. When writing objectives ask yourself "Will the completion of this indicate progress toward achieving the goal?"

STRENGTHS and SKILLS the family will contribute to accomplish the goal:

Strengths and skills the family already has that can be called upon to assist in the achievement of the goal.

Family ID#	Need #	Goal #	ACTIVITIES	# Completed	# Revised	# Deleted

The **PROCESS** necessary for accomplishing the goal include the following activities: Activities are the prescription for accomplishing each objective. Activities describe what the family member, the family consultant, or the partnership will do to achieve each objective. Generally activities reflect an educational, referral/brokerage, delivery of service, or monitoring activity. Activities must include who will do activity, when it will be done, where it will be done, and how often. Service codes and frequency must be entered for each activity, when appropriate.	Start Date	End Date

Please initial to indicate your agreement with the contents of this form:

Family Member:

Family Consultant:

Supervisor:

APPENDIX B

CCDP MIS CODES FOR RECORDING DIFFERENT TYPES OF SERVICES

APPENDIX B: CCDP MIS CODES FOR RECORDING DIFFERENT TYPES OF SERVICES

Child Care

701	Child care in a center
702	Child care in a group home
703	Child care in a family day care home
704	Regular babysitting in a home
705	Drop-in child care
706	Drop-in sick care center
707	Respite/child care/temporary babysitting in a home

Developmental Screening/Assessment

708	Developmental screening
709	Developmental assessment

Child Education

711	Home-based/individual early childhood education with parent present
712	Home-based/individual early childhood education without parent present
713	Center-based/group early childhood education with parent present
714	Center-based/group early childhood education without parent present
715	Head Start
716	Other early childhood education/activities
717	Home-based/individual early intervention education with parent present
718	Home-based/individual early intervention education without parent present
719	Center-based/group early intervention education with parent present
720	Center-based/group early intervention education without parent present
721	Services for school-age children

Adult Education

725	Nutritional parenting education
726	Child development parenting education
727	Health parenting education
728	Other parenting education
729	Adult health education
730	Home management/basic life skills education
731	Vocational training
732	Career counseling
733	Job search training/employment services
734	GED training/high school

Adult Education (*continued*)

735	Literacy training
736	English as Second Language (ESL) training
737	Remedial education
738	College courses

Transportation

741	Transportation subsidy
742	Provide transportation

Nutritional Assistance

751	WIC
752	Food stamps
753	Other food assistance

Income Maintenance

755	AFDC
756	SSI
757	Other public assistance income
758	Unemployment compensation
759	Child support

Housing Services

761	Temporary housing/shelter
762	Low-rent public housing
763	Rent subsidy (private housing)
764	Low-income mortgage assistance
765	Home improvement assistance
766	Utilities assistance

Other Material or Financial Assistance

771	Clothing/household items/other material
772	Emergency funds
773	Child care subsidy
774	School financial aid
775	Small business assistance or loan
776	Low-interest loan

Medical Assistance

781	Medicaid
782	Medicare

Medical Assistance (*continued*)

783	State program for special diseases/disabilities
784	Other medical payment assistance

Family Services/Legal Intervention

791	Child protective services
792	Foster care
793	Adoption
794	Child support enforcement
795	Intervention for domestic violence
796	Other family services/legal intervention

Other Social Services

797	Parent/peer support group
798	Recreational activities
799	Other social service

Other Screening/Assessment

803	Medical history
804	Dental screening
805	Disability screening
806	Hearing screening/assessment
807	HIV screening
808	Mental health screening
809	Nutritional assessment
810	Speech/language evaluation
811	Vision screening/assessment
812	Other health screening
813	General physical exam and assessment

Immunization

815	Polio
816	Diphtheria, Pertussiis, and Tetanus
817	Mumps, Measles, and Rubella
818	Tetanus
819	Flu
820	Haemophilus influenzae b
821	Tuberculosis
822	Pneumococcal
823	Varicella
824	Other immunization

Diagnostic Tests

825	Amniocentesis
826	Blood pressure
827	Pregnancy testing
828	Lab test
829	X-ray
830	Electrocardiogram
831	CAT SCAN/MRI
832	Ultrasound
833	Other medical diagnostic services

Maternal/Newborn Care

835	Prenatal care
836	Well-baby care
837	Postpartum care

Counseling or (Re)habilitation Visit

841	Alcohol abuse counseling
842	Drug abuse counseling
843	Family planning counseling
844	Family therapy
845	Hearing therapy
846	Marriage counseling
847	Mental health counseling
848	Nutritional counseling
849	Obesity therapy sessions
850	Occupational therapy sessions
851	Physical therapy sessions
852	Smoking cessation counseling
853	Speech therapy sessions
854	Stress reduction counseling
855	Vision therapy

Other Outpatient Treatment

861	Emergency Room Treatment
862	Acute illness outpatient care
863	AIDS outpatient care
864	Hypertension (High Blood Pressure) outpatient care
865	Chronic respiratory disorder outpatient care
866	Other chronic illness outpatient care
868	Dental treatment
869	Outpatient/ambulatory surgery

Overnight Stay in a Hospital

872	Vaginal delivery
873	Caesarean section
874	Neonatal admission (separate admission of newborn)
875	AIDS inpatient care
876	Alcohol abuse inpatient care
877	Drug abuse inpatient care
878	Mental disorder/psychiatric inpatient care
879	Physical rehabilitation inpatient care
880	Accident/injury inpatient care
881	Other medical/surgical inpatient care
882	Followup for health/medical services or treatment

Partial/Day Hospital Program

885	Alcohol Abuse Day Program
886	Drug Abuse Day Program
887	Mental Health/Psychiatric Day Program
888	Physical Rehabilitation Day Program

Health/Medical Device

898	Health/medical device/prescription

Case Management with Family

901	Needs assessment with family
902	Planning with family
903	Review with family of services received
904	Review and followup with provider on services received
905	Supportive discussion with family
906	Translation services
907	Individual followup

APPENDIX C

DESCRIPTION OF THE IMPACT EVALUATION SAMPLE

APPENDIX C: DESCRIPTION OF THE IMPACT EVALUATION SAMPLE

This appendix contains a description of the baseline characteristics of the sample of families participating in the Comprehensive Child Development Program (CCDP) national impact evaluation. The data represent measures on families as of 1990, the year when most of the recruiting for the CCDP evaluation took place. Data presented in this section were taken from the recruitment and family profile forms maintained by CSR, Incorporated, as part of its responsibilities as CCDP's technical support contractor and from recall data supplied by evaluation participants. The analyses for this section are based on data from all 4,411 families that were part of the original random assignment to participate in the CCDP impact evaluation, either as a program family or as a control family.

CHARACTERISTICS OF CHILDREN IN THE IMPACT EVALUATION

Child-level data are supplied for the "focus child" in each family in the evaluation. The focus child was identified at the time of recruitment into the study. The plan was that focus children would either be newborn infants or would be born soon after recruitment.

One-half of the children participating in the CCDP evaluation are males (49.7 percent), and one-half are females (50.3 percent). The race/ethnicity of participating children is shown in Exhibit C-1 following the next page, and three racial/ethnic groups account for most of the sample: 42.2 percent of children in the sample are African-American, 27.3 percent are Hispanic, and 26.4 percent are Caucasian. In addition, 2.7 percent are American Indian and 1.4 percent are Asian-American.

Exhibit C-2 shows the distribution of the age of focus children at the time of recruitment into the CCDP evaluation. Women with unborn children were recruited as well as mothers with newborns. Unborn children are shown in the exhibit as having an age less than 0. Almost one-third of the mothers in the evaluation (30.5 percent) were pregnant when recruited into the program. Another 5.9 percent were recruited when their children were newly born. The remaining 63.6 percent were recruited after their children were 1 or more months of age. This exhibit shows the wide age range of focus children participating in the evaluation—the youngest CCDP children are about 2 years younger than the oldest CCDP children.

CHARACTERISTICS OF MOTHERS AND FAMILIES IN THE IMPACT EVALUATION

Although CCDP provides services to many adults in a household, the evaluation focuses on the mother who was recruited into the evaluation. Exhibits C-3 through C-9 following this page describe the mothers and families originally assigned to participate in the evaluation.

The primary language of the families in the evaluation sample are shown in Exhibit C-3. The great majority (83.6 percent) of families use English as their primary language, while 14.2 percent use Spanish as their primary language, and 2.2 percent use some other primary language.

Exhibit C-4 shows the ages of the mothers in the evaluation sample at the time of birth of the focus children. About one-fourth of the mothers (25.2 percent) were teenagers when recruited into CCDP. Another 58.2 percent were in their twenties, and the remaining 16.6 percent were age 30 or older.

A distribution of the educational status of mothers in the sample is given in Exhibit C-5. A substantial fraction of CCDP mothers (13.5 percent) never entered high school. A larger proportion of the mothers (38.6 percent) completed some high school but did not graduate. Finally, almost one-half of the mothers (47.9 percent) graduated from high school.

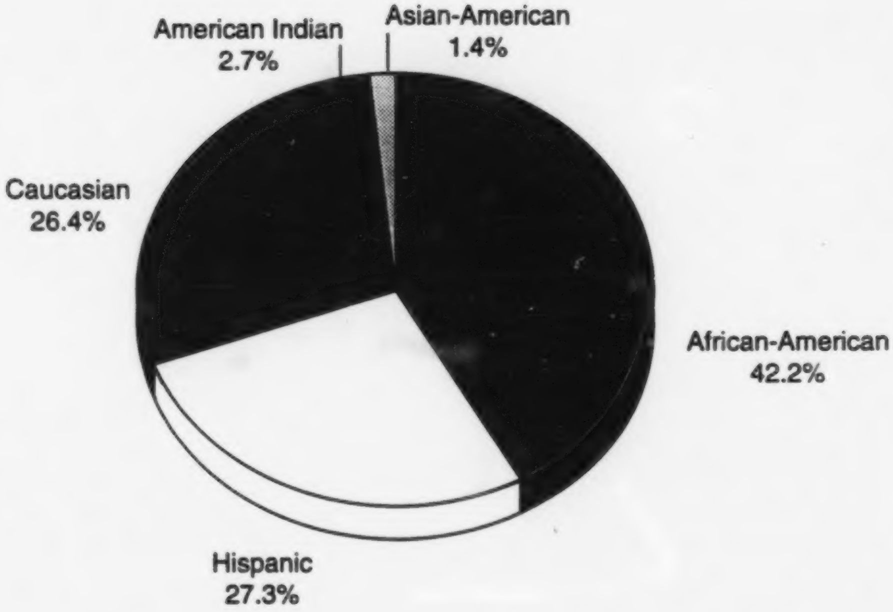
Exhibit C-6 shows the marital status of the mothers in the evaluation. More than one-half of the mothers (57.7 percent) were single and without a partner at the time of recruitment into the evaluation, and one-fourth (25.2 percent) were married. This pattern is just the reverse of national statistics. The Current Population Survey estimates that, during 1988, 55.7 percent of the women who had babies were married and 29.9 percent were single. The remainder of the mothers in the evaluation were either separated (6.6 percent), single and living with a partner (5.9 percent), or widowed or divorced (4.6 percent).

Information also was obtained regarding the presence of a father or father figure in the home. There is no father or father figure in the home for two-thirds of the families in the evaluation (66.6 percent), while a father or father figure is present in the home in one-third (33.4 percent) of the families.

Several variables characterize the poverty level of the families in the evaluation. Two-thirds of the families (66.1 percent) live in subsidized housing, and 58.0 percent do not have their own transportation. Exhibits C-7, C-8, and C-9 provide distributions of total household income, number of household members, and per person income for the evaluation sample. As can be seen, almost one-half of the families in the evaluation sample (44.1 percent) have a total annual household income under $5,000. Another 41.3 percent have a household income between $5,000 and $10,000. The remaining 14.6 percent have incomes over $10,000 per year. Household

Exhibit C-1

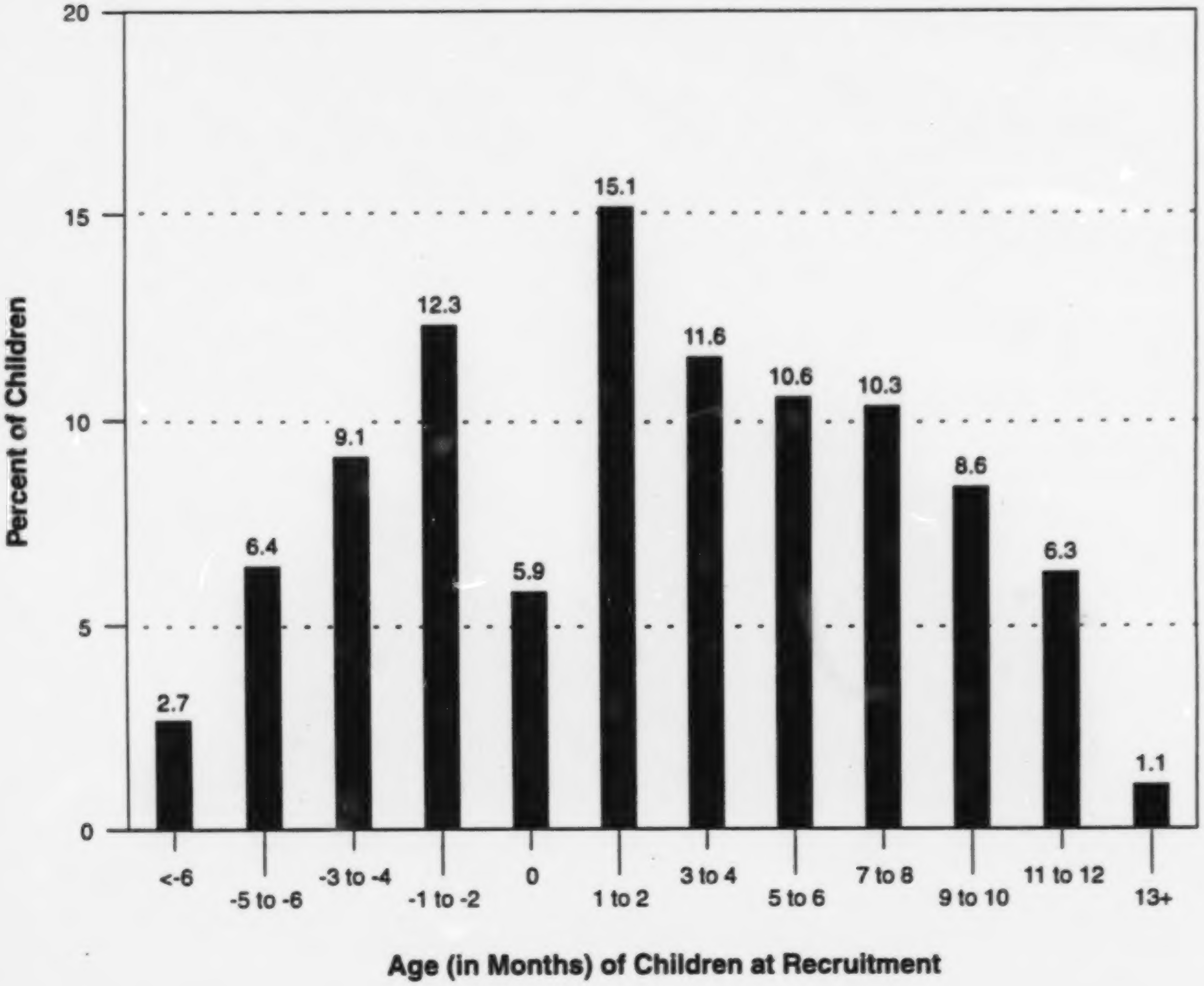
Race/Ethnicity of Children in the CCDP Impact Evaluation Sample



Source: MIS family profile at baseline

Exhibit C-2

Age (in Months) of Children at Recruitment in the CCDP Impact Evaluation Sample



SOURCE: MIS family profile at baseline

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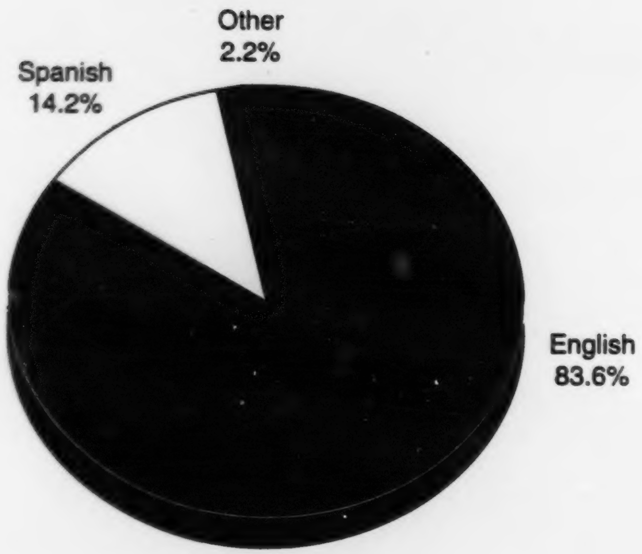
Exhibit C-3

Primary Languages Used by Families in the CCDP Impact Evaluation Sample

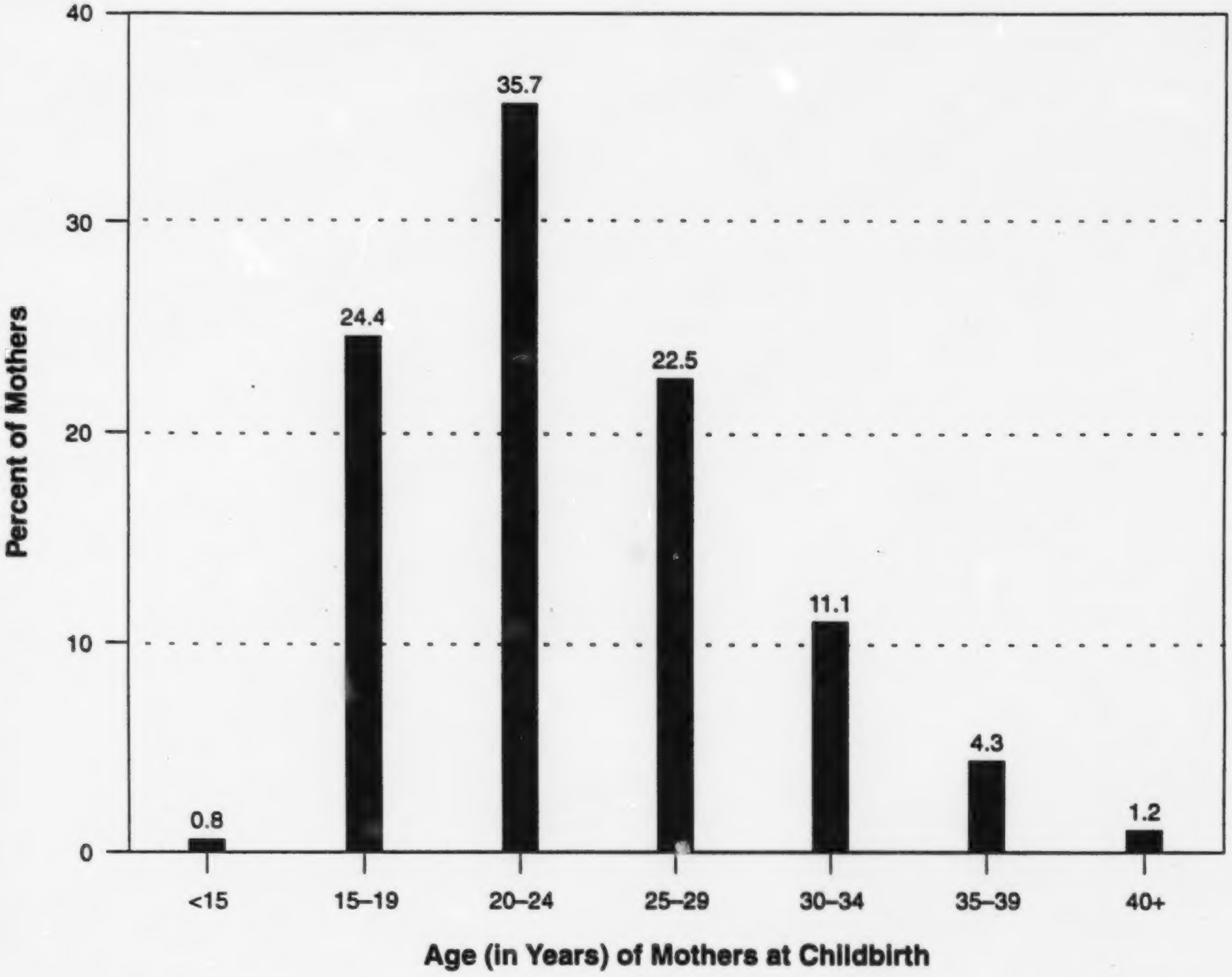


Source: MIS family profile at baseline

#22593

Exhibit C-4

Age (in Years) at Childbirth for Mothers in the CCDP Impact Evaluation Sample



SOURCE: MIS family profile at baseline

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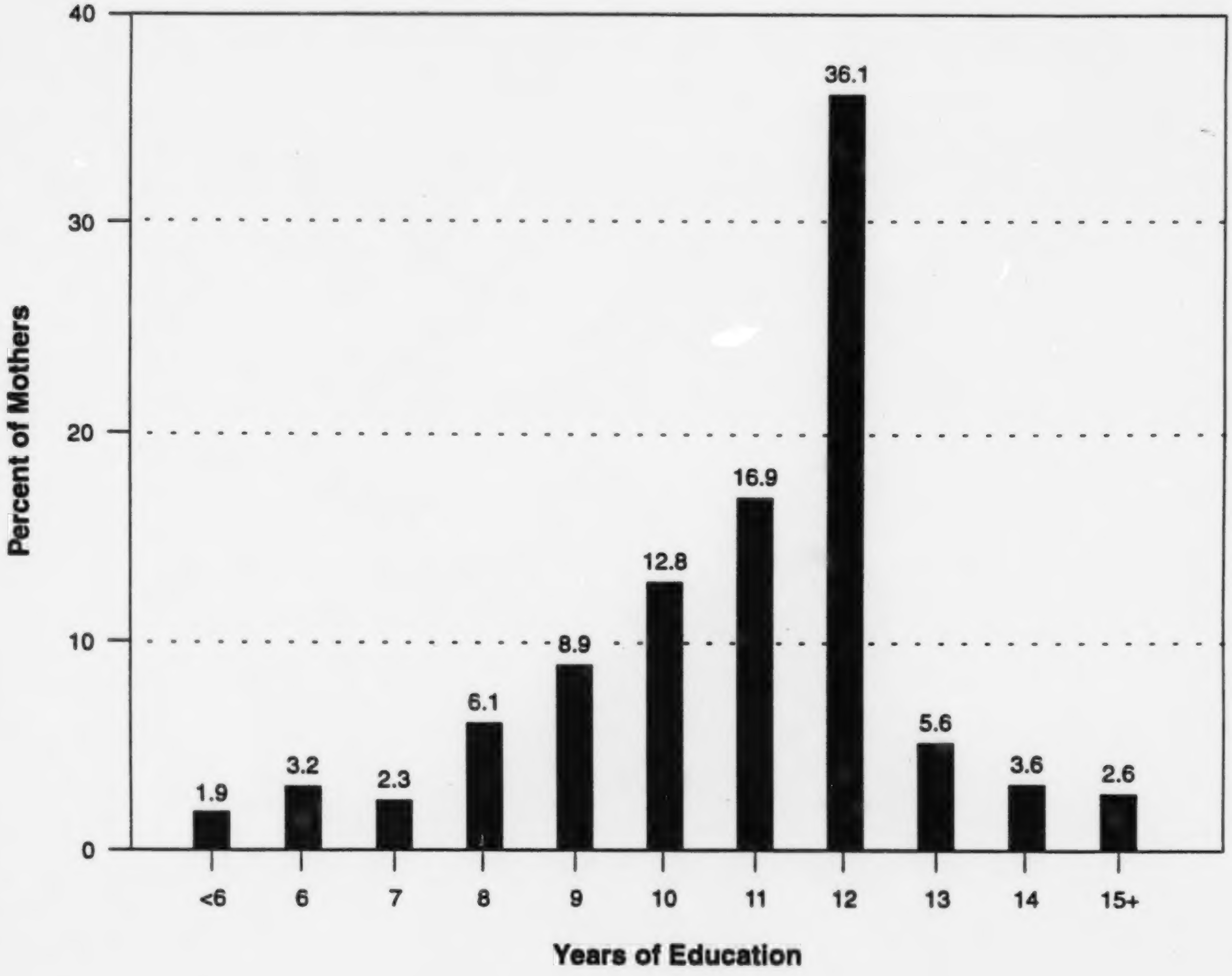
Exhibit C-5

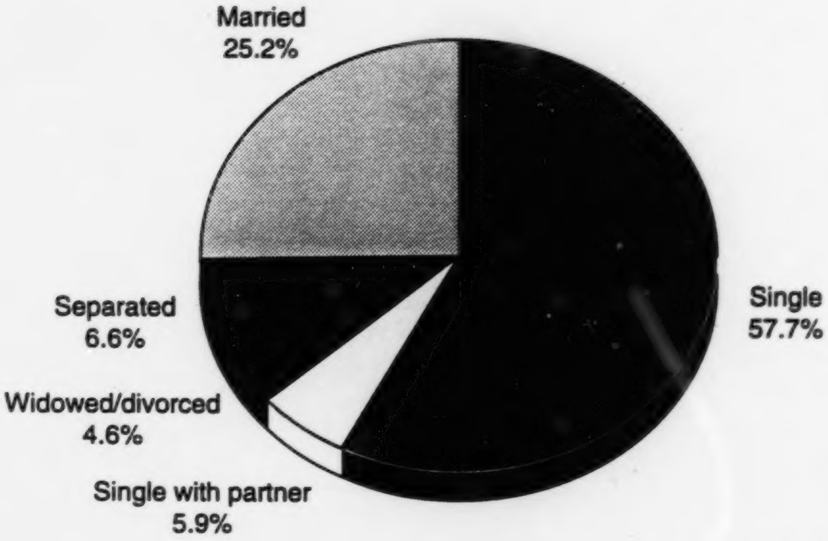
Years of Education for Mothers in the CCDP Impact Evaluation Sample



SOURCE: MIS family profile at baseline

Exhibit C-6

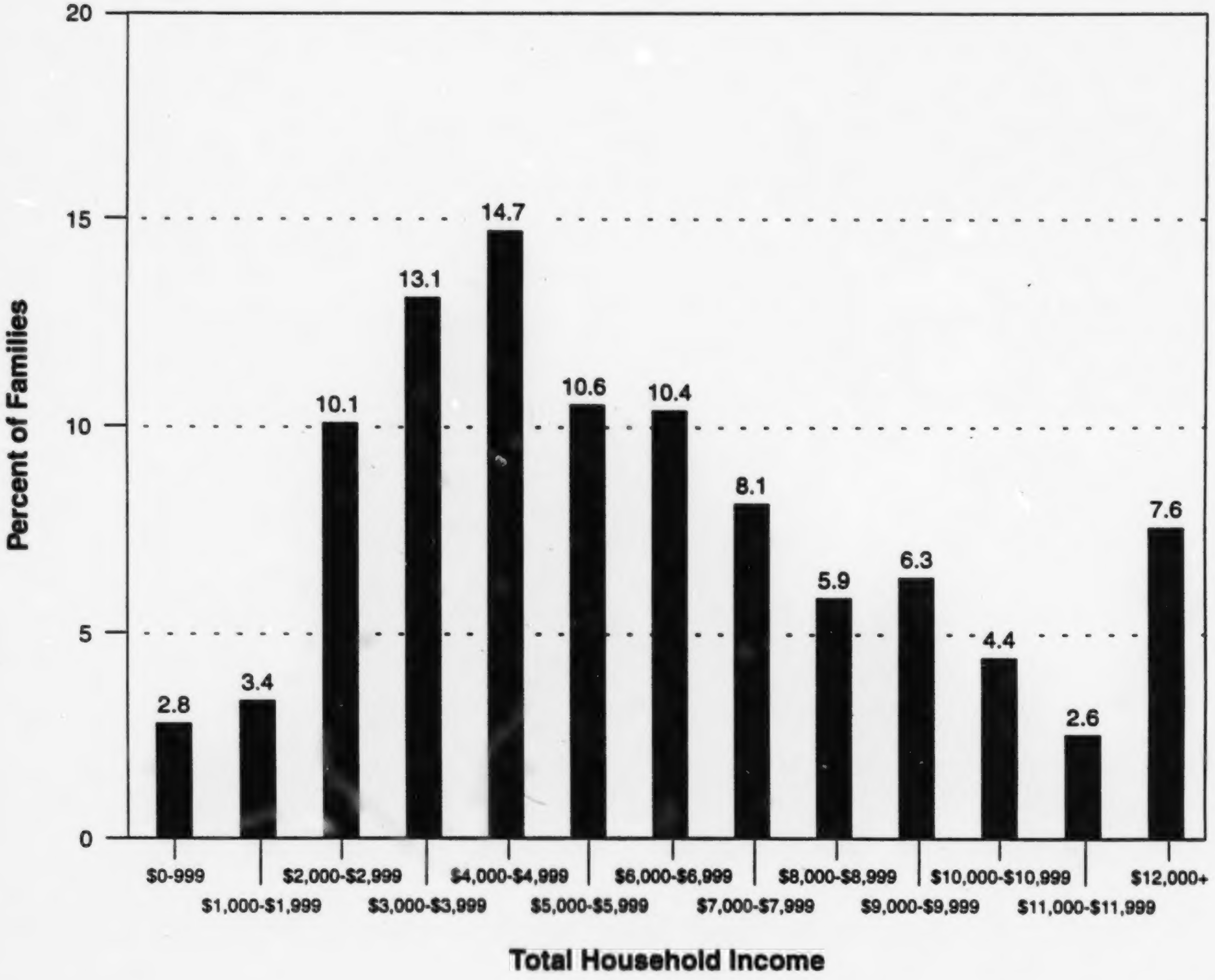
Marital Status of Mothers in the CCDP Impact Evaluation Sample



Source: MIS family profile at baseline

Exhibit C-7

Total Household Income for Families in the CCDP Impact Evaluation Sample



SOURCE: MIS family profile at baseline

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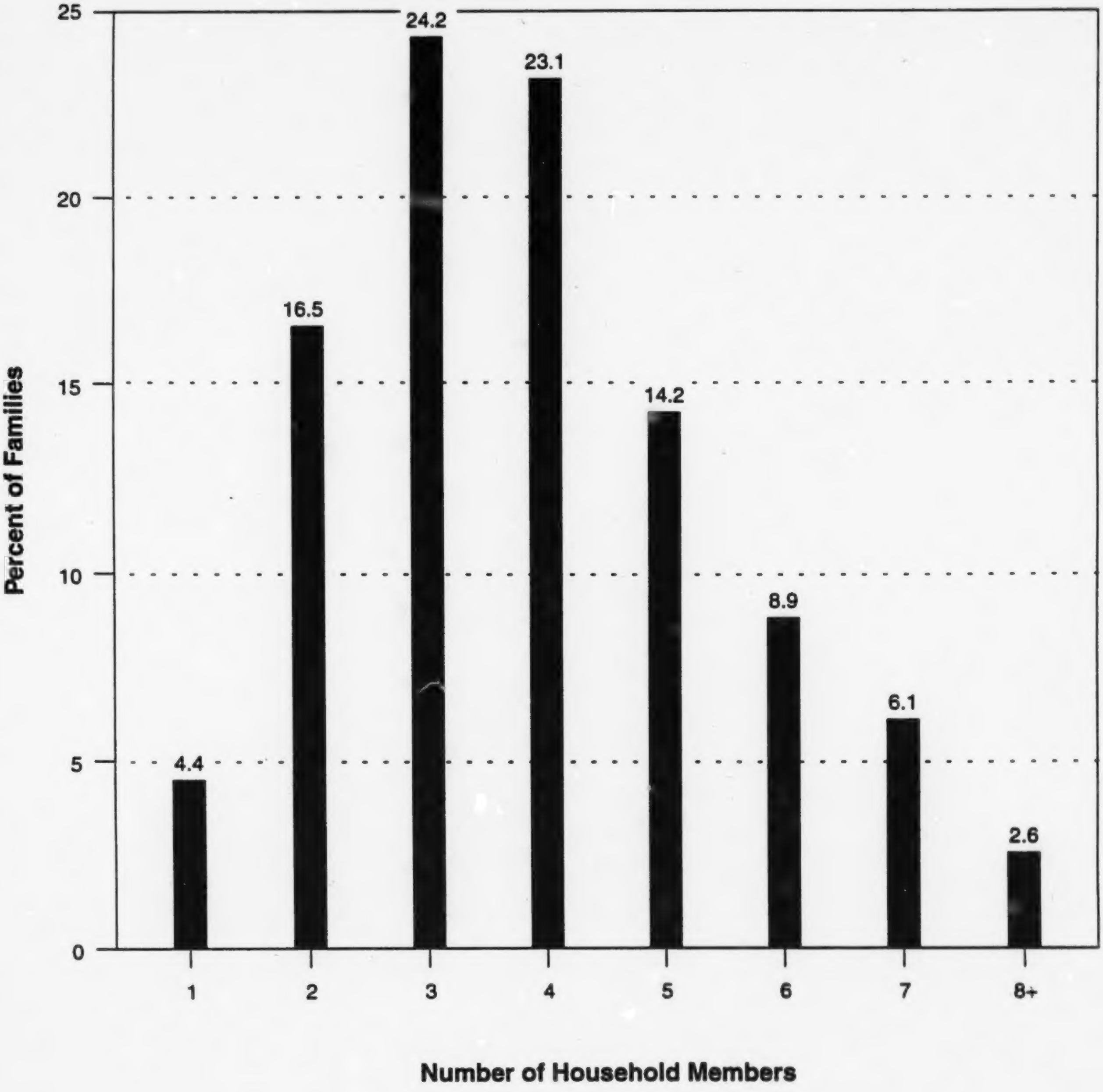
Exhibit C-8

Number of Household Members for Families in the CCDP Impact Evaluation Sample



SOURCE: MIS family profile at baseline

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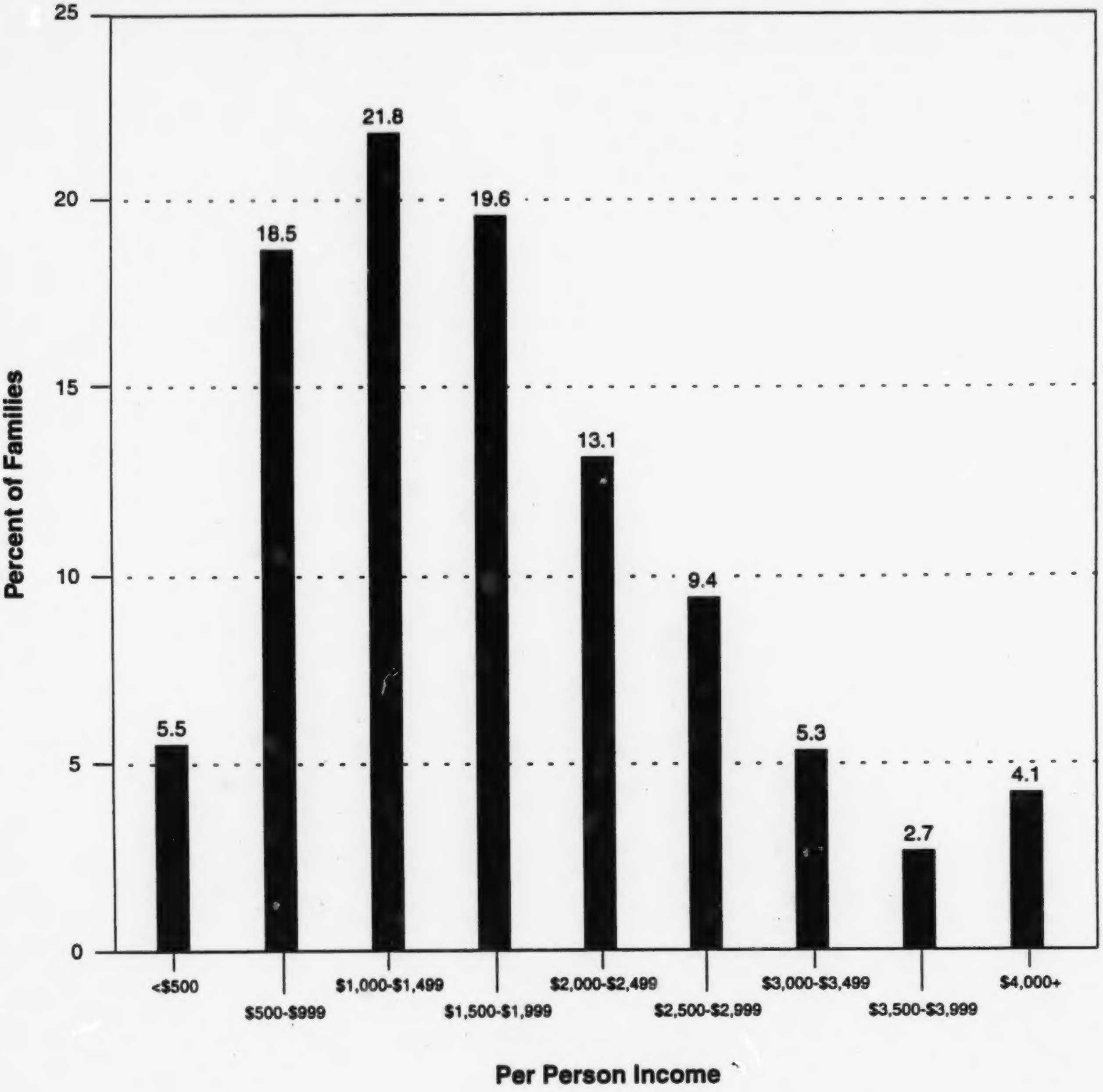
Exhibit C-9

Per Person Income for Families in the CCDP Impact Evaluation Sample



SOURCE: MIS family profile at baseline

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size ranges from one family member (4.4 percent pregnant women with no other household members) to eight or more family members. Most families have two (16.5 percent), three (24.2 percent), four (23.1 percent) or five (14.2 percent) members. Per person income mostly falls in the range of $500 to $2,400 per year.

RISK FACTORS FOR CHILDREN IN THE IMPACT EVALUATION

In addition to the basic descriptive information presented above, interview data about behaviors during pregnancy, which were collected from mothers participating in the evaluation, were used to construct a set of "risk factors" for the focus children, factors that could well affect a child's cognitive, socioemotional, and physical development. Information about the risk factors is displayed in Exhibits C-10 through C-16 following the next page.

One risk factor is the number of months that the mother was pregnant with the focus child before she first saw a doctor about her pregnancy. Mothers who do not see a doctor or who wait until late in their pregnancy before seeing a doctor are unlikely to receive appropriate prenatal care. Exhibit C-10 shows that more than three-fourths (77.4 percent) of the mothers in the evaluation sample saw a doctor during the first trimester of their pregnancy with the focus child. Another 19.3 percent waited until the second trimester before seeing a doctor. Only 3.3 percent did not see a doctor until the final trimester of their pregnancy.

A second risk factor is whether the child was born prematurely. Exhibit C-11 shows that over three-fourths (78.3 percent) of the children in the evaluation were full term. Of the remainder, 3.6 percent were 1 week premature, 6.2 percent were 2 weeks premature, 2.8 percent were 3 weeks premature, 4.8 percent were 4 weeks premature, and 4.3 percent were 5 or more weeks premature.

The third risk factor is a count of the number of pregnancy-related problems that the mother encountered while pregnant with the focus child. Clearly, the greater the number of problems, the more likely it is that one or more will have a negative effect on the child. Examples of such problems include toxemia, premature labor, weight loss, and placenta previa. Exhibit C-12 shows that three-fourths of the mothers reported having experienced no pregnancy-related problems, 13.8 percent reported one problem, 4.9 percent reported two problems, 2.7 percent reported three problems, and 1.0 percent reported four or more problems.

Another indication of health-related problems for children is whether the child had to spend time in a hospital's special care unit after birth. As is shown in Exhibit C-13, more than four-fifths of the children in the sample (86.3 percent) did not spend any time in a special care unit. On the other hand, 7.1 percent of the children in the evaluation sample spent 1 to 5 nights in special care, 2.8 percent spent 6 to 10 nights, and 3.8 percent spent 11 or more nights in the hospital.

Low birth weight (under 2,500 grams) and very low birth weight (under 1,500 grams) are key indicators of children who are likely to have developmental problems. Exhibit C-14 shows that a very small percentage of children in the sample were very low-birthweight babies (1.4 percent), while an additional 8.3 percent were low-birthweight babies. According to the National Center for Health Statistics, 6.9 percent of all births across the Nation during 1988 were low birth weight. Most of the children in the sample (81.4 percent) weighed between 2,500 and 4,000 grams, while 8.9 percent weighed over 4,000 grams.

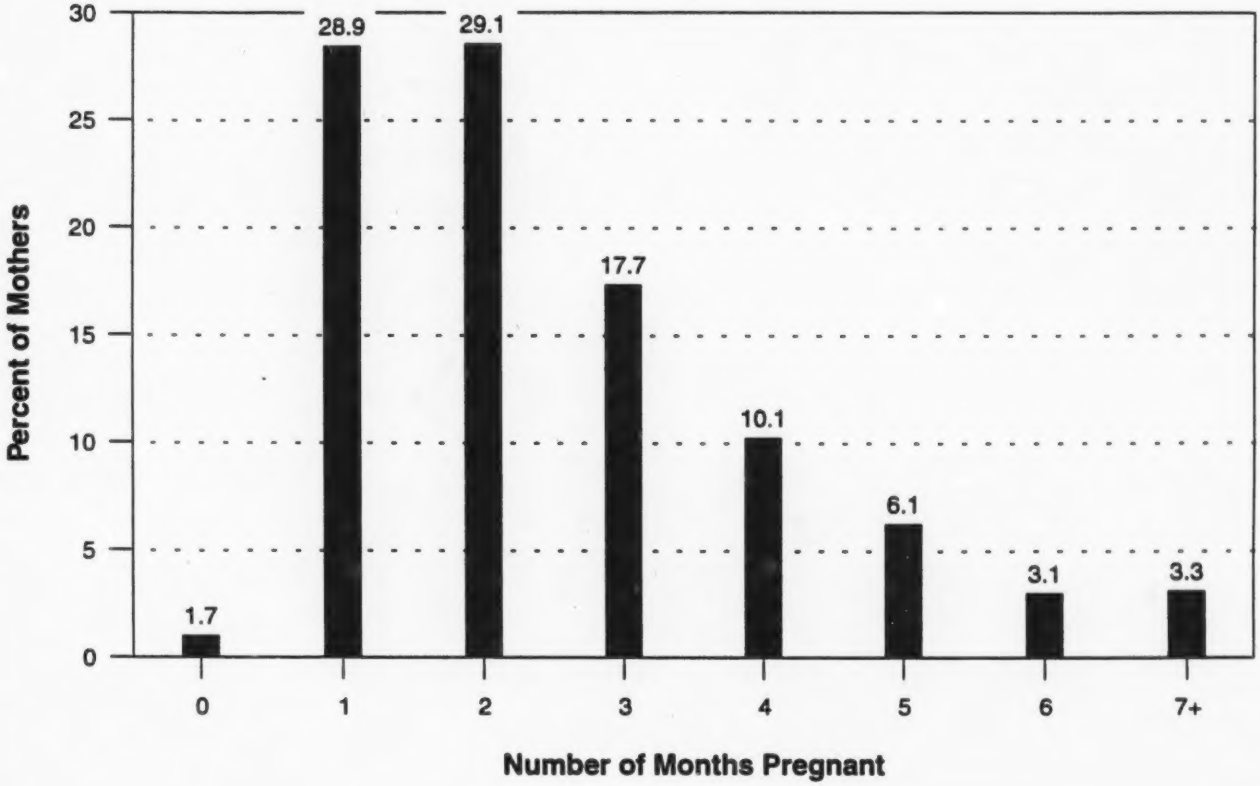
Three additional indicators of risk for children are whether their mothers smoked, used alcohol, or used drugs during pregnancy. Exhibit C-15 shows that 71.2 percent of the mothers reported that they did not smoke at all during their pregnancy with the focus child. Two percent reported smoking less than 1 cigarette per day, 9.3 percent smoked between 1 and 5 cigarettes per day, 10.3 percent smoked about one-half of a pack (between 6 and 15 cigarettes per day), 5.8 percent smoked about 1 pack (between 16 and 25 cigarettes per day), and only 1.4 percent smoked more than 26 cigarettes per day.

Exhibit C-16 shows that 87.9 percent of the mothers reported that they did not drink any alcoholic beverages during their pregnancy. An additional 6.4 percent drank only a few times during the pregnancy, 2.3 percent had a few drinks per month, 1.6 percent drank once a week, 1.3 percent had a few drinks per week, and 0.5 percent drank daily.

Finally, although not shown in an exhibit, only 2.7 percent of the mothers in the evaluation sample reported any drug use during pregnancy.

Exhibit C-10

Number of Months Mother Was Pregnant With Focus Child When She First Saw a Doctor

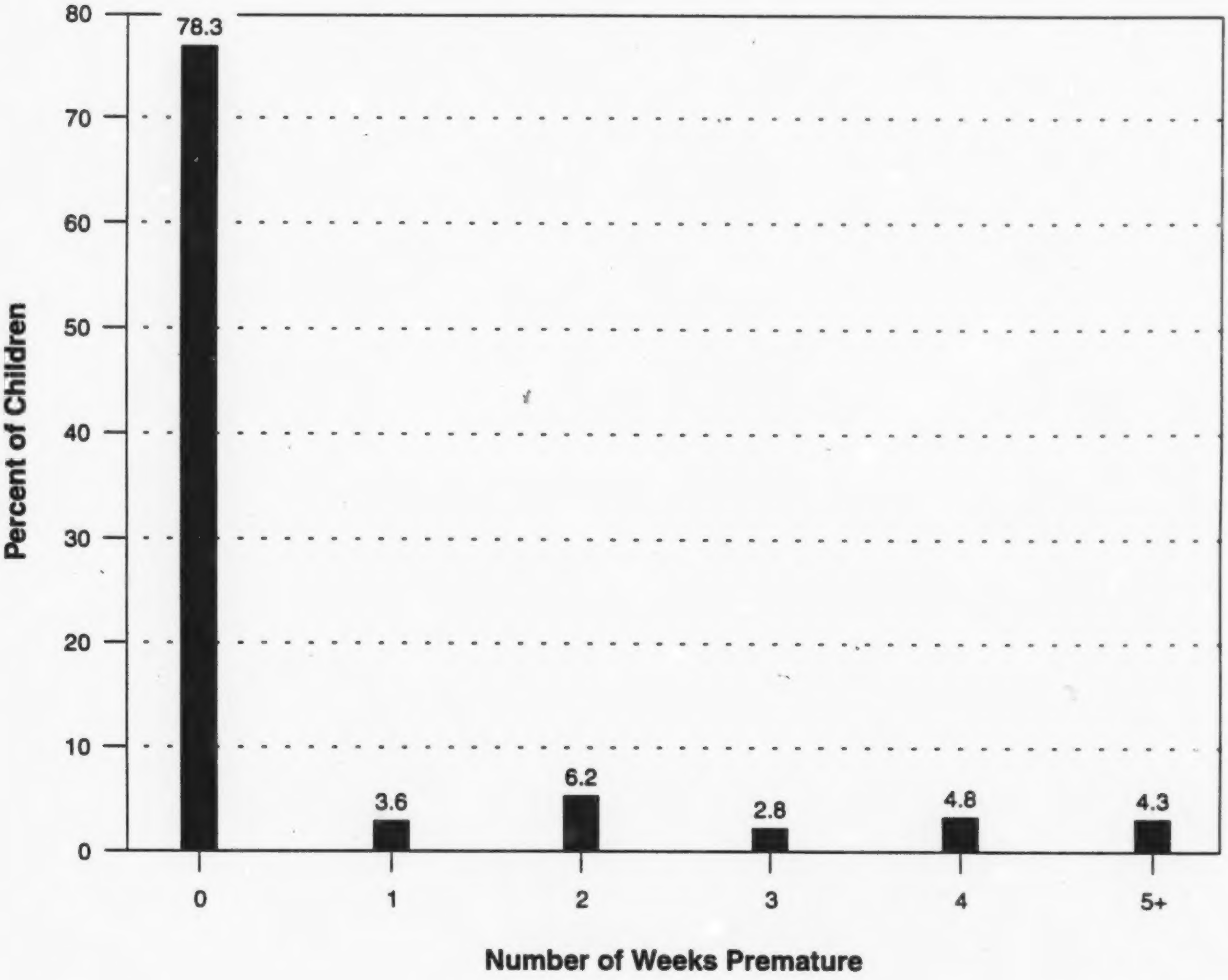


SOURCE: Parent interview survey items

#22593

Exhibit C-11

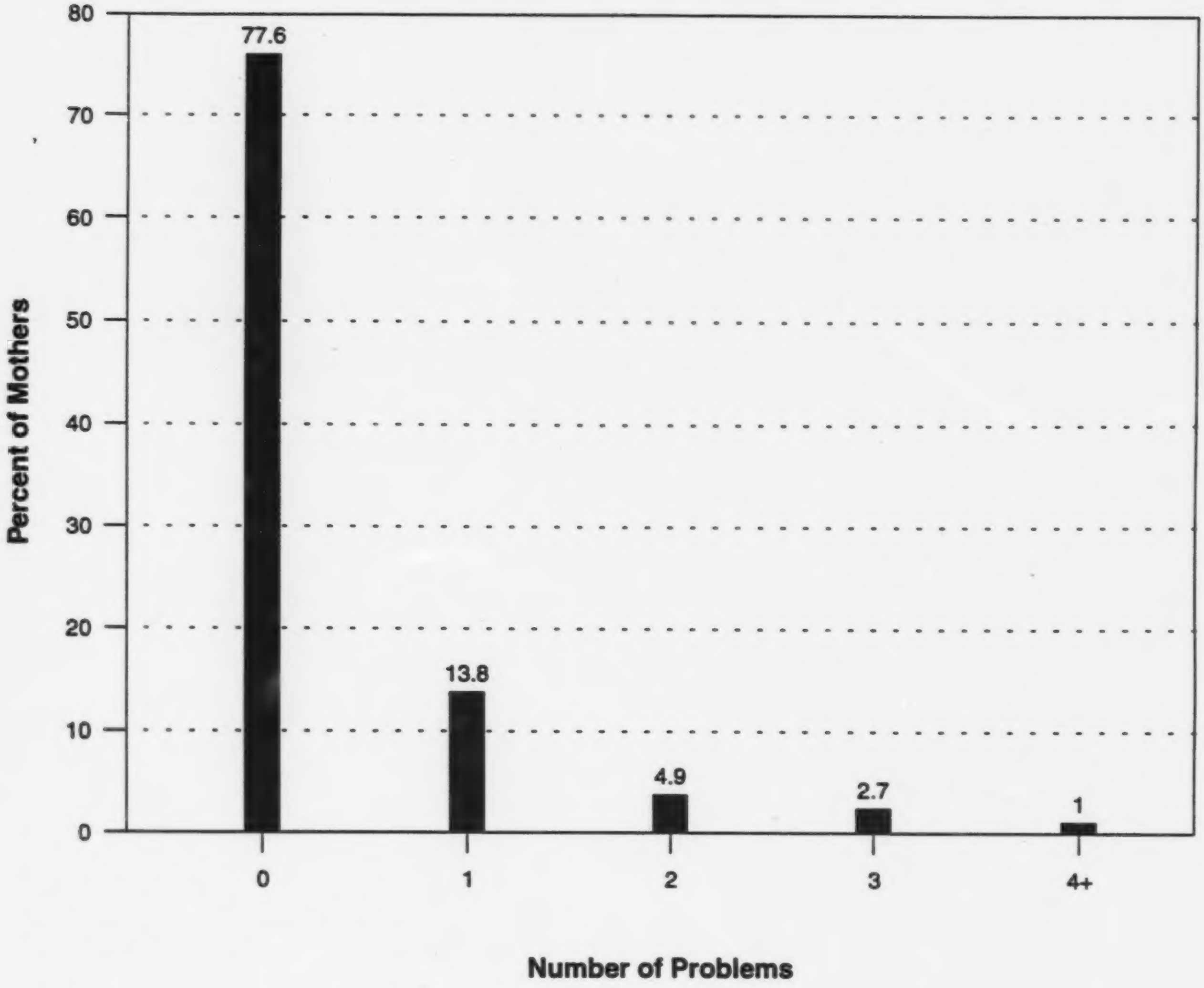
Number of Weeks Focus Child Was Premature



SOURCE: Parent interview survey items

Exhibit C-12

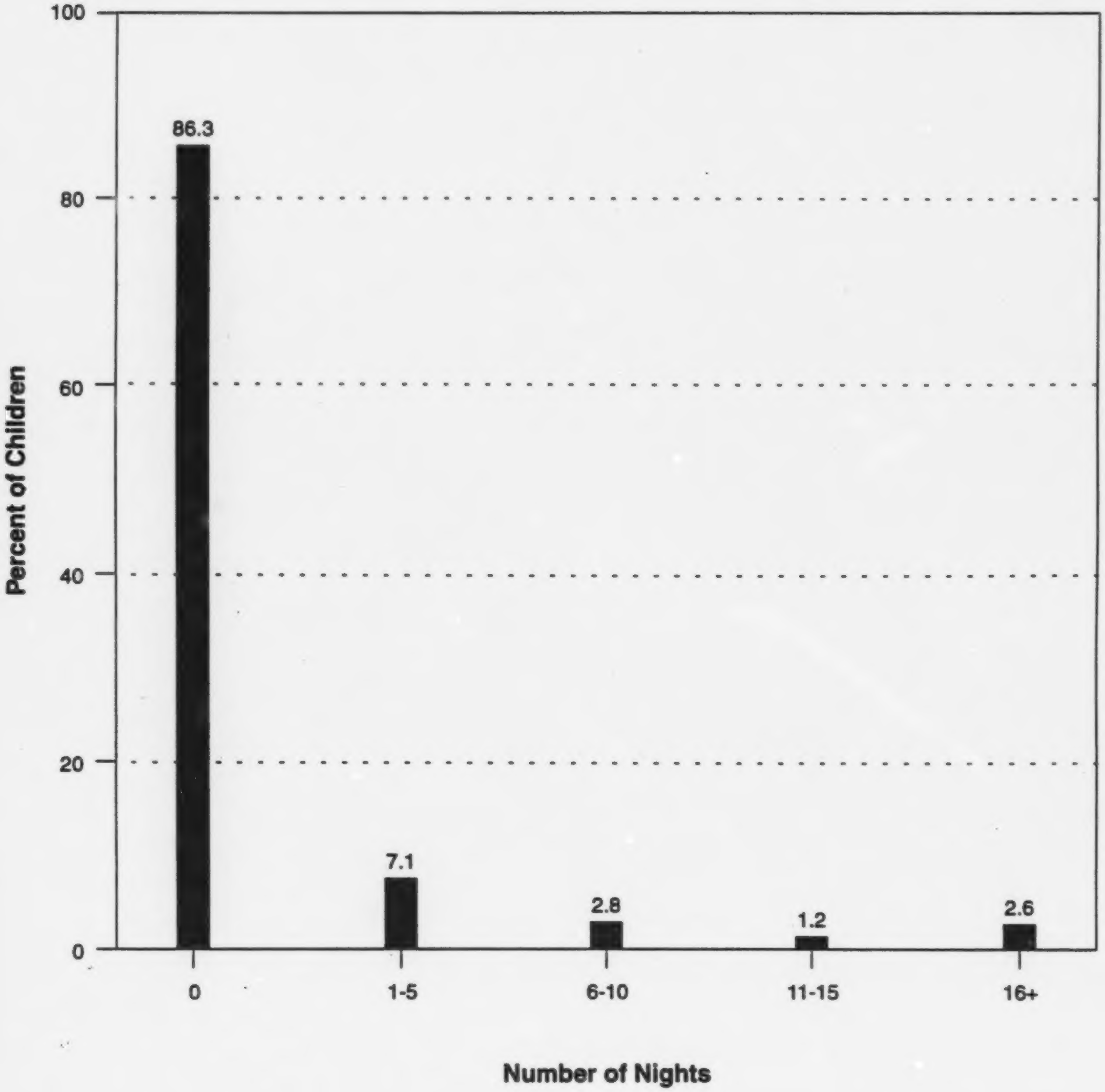
Number of Problems During Pregnancy



SOURCE: Parent interview survey items

Exhibit C-13

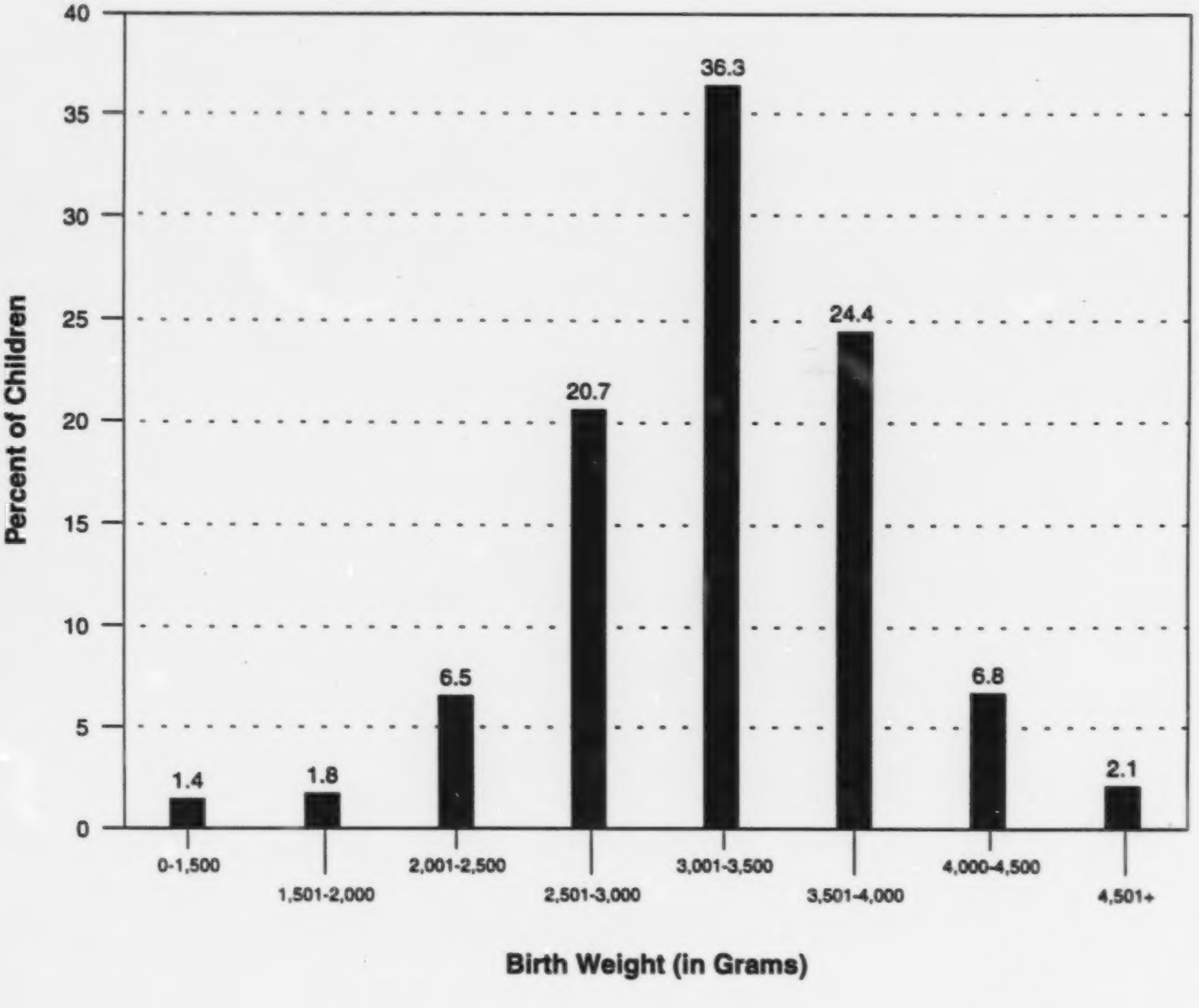
Number of Nights in Special Care Unit



SOURCE: Parent interview survey items

Exhibit C-14

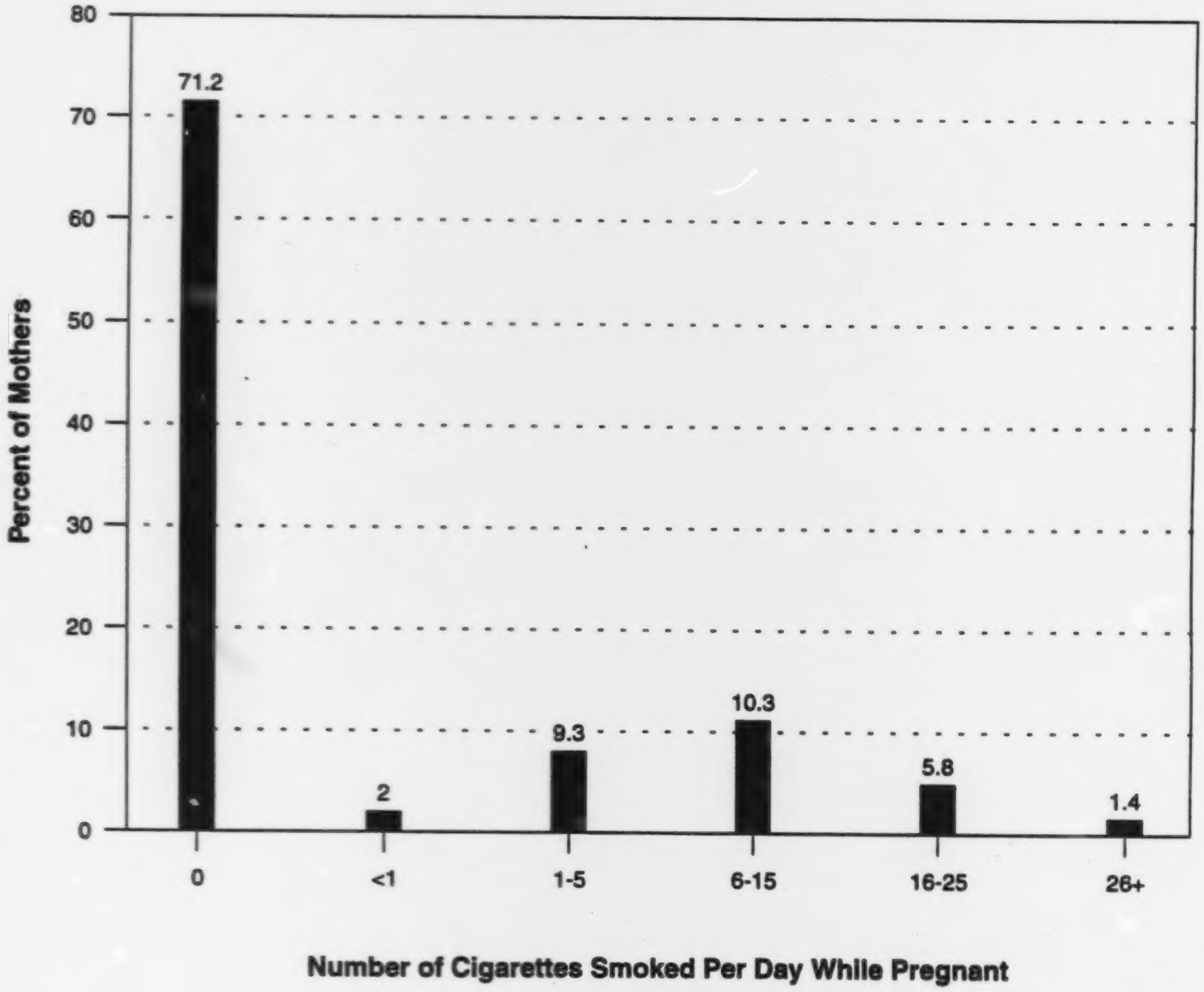
Birth Weight (in Grams) for Focus Children in the CCDP Impact Evaluation Sample



SOURCE: Parent interview survey items

Exhibit C-15

Number of Cigarettes Smoked Per Day While Pregnant

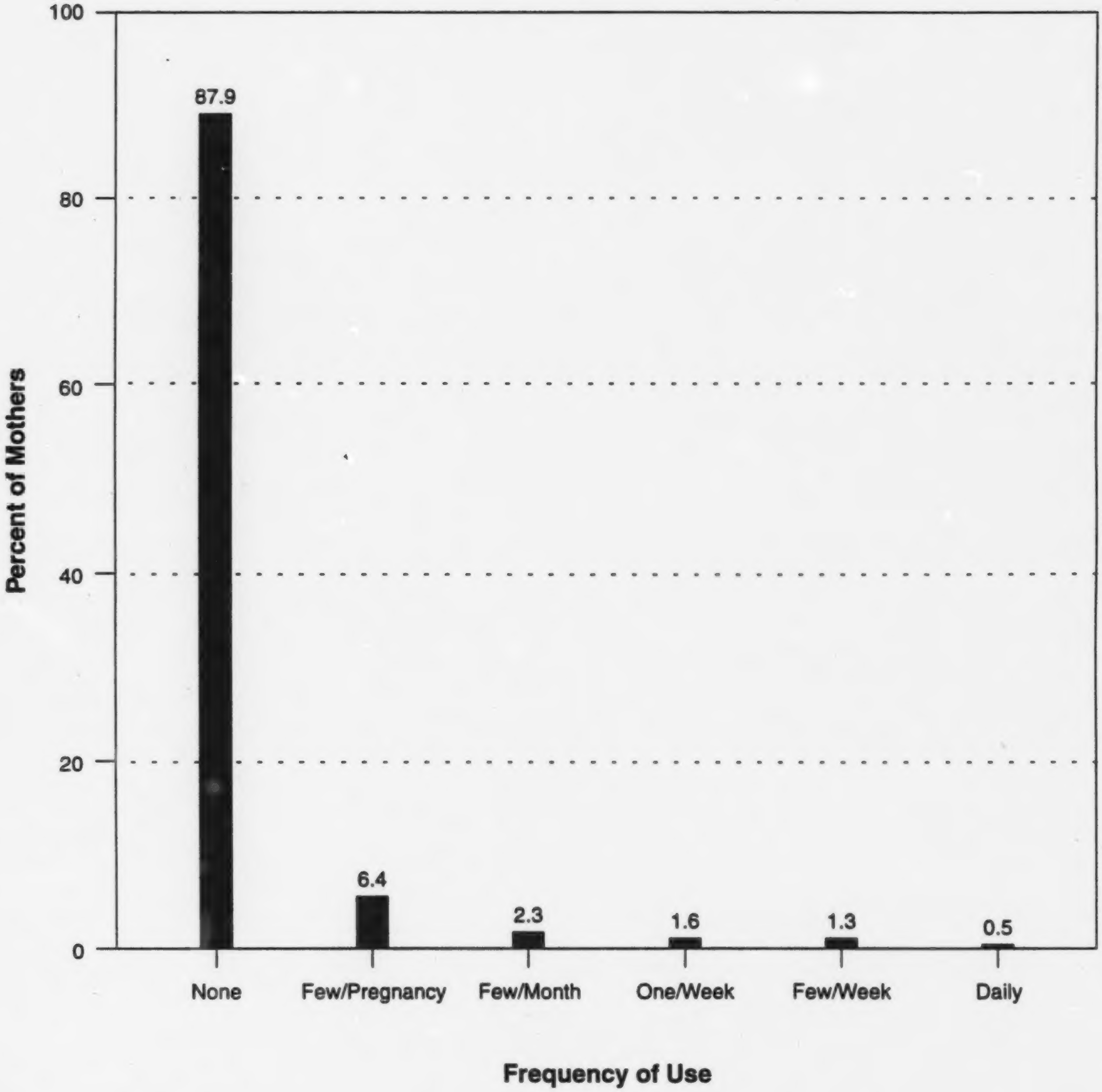


SOURCE: Parent interview survey items

#22593

Exhibit C-16

Frequency of Alcohol Use While Pregnant



SOURCE: Parent interview survey items

#22593

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Head Start Bureau

COMPREHENSIVE CHILD DEVELOPMENT PROGRAM—A NATIONAL FAMILY SUPPORT DEMONSTRATION

INTERIM REPORT TO CONGRESS

Executive Summary

Allen N. Smith, CCDP Project Officer
Michael Lopez, Impact Evaluation Project Officer
Head Start Bureau
Administration on Children, Youth and Families
Administration for Children and Families
U.S. Department of Health and Human Services

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 6 1994

The Honorable Edward M. Kennedy
Chairman, Committee on Labor
and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Section 670N [42 U.S.C. 9881] (f) of the Comprehensive Child Development Centers Act, as amended, requires that the Secretary of the Department of Health and Human Services submit a report to the Congress concerning the results of the evaluation of the projects funded under the Act in order to determine their effectiveness in achieving stated goals, their impact on related programs, and their structure and mechanisms for the delivery of services.

The Comprehensive Child Development Program (CCDP), authorized under the Act, is required to provide intensive, comprehensive, integrated and continuous support services to children from low-income families from birth until entrance into elementary school to enhance their intellectual, social and physical development; and to provide needed support services to parents and other household family members to enhance their social and economic self-sufficiency.

Enclosed is the mandated report, delivered as an interim report, with the final report being scheduled for delivery to the Congress in March 1996. This extension is needed to allow currently enrolled families to receive the required five years of services and thus enable the Department to provide a sound assessment of the complete impact of the CCDP on the lives of these families and their children. The interim report covers the period from September 1989 through March 1993, which includes the start-up year and two-and-one-half years of service delivery to families.

I am pleased to submit the Interim Report to Congress: Comprehensive Child Development Program -- A National Family Support Demonstration.

Sincerely,

Donna E. Shalala

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON D.C. 20201

MAY 6 1994

The Honorable William D. Ford
Chairman, Committe on Education
and Labor
House of Representatives
Washington, D.C. 20515

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Sincerely,

Donna E. Shalala

Enclosure

EXECUTIVE SUMMARY

HIGHLIGHTS

Authorized by Congress in 1988, the Comprehensive Child Development Program (CCDP) is designed to address the pervasive needs of low-income children and families and to combat the fragmentation of existing programs that serve them. Its objective is to promote educational achievement and economic and social self-sufficiency through the provision of intensive, comprehensive, and continuous support to both children and families from a child's birth until entry into school. Focusing on goals set by each individual family, CCDP acts as an advocate and broker, helping families access services in the community, and helping communities integrate and improve the services they offer. The program also provides services directly when they are not available locally.

Evaluation studies are examining the program's implementation, service delivery, and cost, as well as its impact on children and families. Major interim findings, when families had been in the program only 2 years or less, indicate the following:

- CCDP is serving the low-income, multirisk families it was intended to serve.
- CCDP has been implemented successfully in diverse cities and rural areas, requiring a startup period of about 1 year.
- CCDP programs nationwide have coordinated the services of thousands of community agencies, both public and private.
- CCDP is coordinating and delivering a wide range of services to children and families, including health care and screenings; early childhood education; parent training; adult education; counseling and rehabilitation; housing assistance; and subsidies for child care, medical payments and emergencies.
- Services are reaching a high proportion of participating families. For example, 80 percent of CCDP mothers receive regular parent education in their homes, and others attend classes outside the home. Children in 77 percent of CCDP families receive regular, in-home early childhood education, and others participate in center-based programs. About 75 percent of children receive periodic developmental screenings, and 78 percent of families receive various forms of health care screening.

- Between 80 percent and 95 percent of participants have either achieved the goals they identified at entry or have made significant progress toward achieving them.

- Compared to a randomly selected control group:

  — CCDP mothers are more likely to be enrolled in academic classes or job training;

  — CCDP families make more use of community resources, such as early childhood programs, health services, and public assistance;

  — CCDP mothers interact more positively with their children, have higher expectations for them, and exhibit fewer attitudes associated with child abuse and neglect;

  — CCDP children score higher on a standard developmental scale, exhibit more prosocial behavior (e.g., are more cooperative and follow rules), and suffer fewer injuries requiring hospitalization.

- Nonresearch costs of the program average $8,243 per family per year ($2,137 per family member per year), with a range across sites from $4,592 to $13,413.

A final report will be delivered to Congress in 1996, after families have been in the program the full 5 years.

THE PROGRAM: SUPPORTING CHILDREN AND FAMILIES TO BREAK THE CYCLE OF POVERTY

This section details the history and purpose of CCDP, including need, legislation, projects, goals, eligibility and program requirements, and what makes CCDP different from other programs.

Need

CCDP was conceived against a backdrop of pressing problems faced by low-income families and their children—inadequate housing, health care and nutrition, family breakup, teenage pregnancy, lack of positive role models and growth experiences for children, and poor educational attainment and employment prospects—that often lead to crime or welfare dependency.

Aside from a few exemplary demonstration projects, existing programs for low-income families fail to attack these problems on a broad front. Typically, services are provided through categorical programs addressing a single need. Thus from the family's point of view, services often are

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fragmented, confusing, and often inaccessible. Also, existing services usually fail to reach enough low-income families early enough in their children's lives or for long enough to make a difference.

Legislation

Congress established CCDP specifically to address these concerns. The program was authorized by the 1988 Comprehensive Child Development Centers Act, Sections 2501-2504 of Public Law 100-297 ("the act"). Under the act, the Department of Health and Human Services (DHHS) funded 24 projects for a 5-year period, beginning in Fiscal Years (FY's) 1989 and 1990, at a total annual cost of $25 million. Management at the Federal level is the responsibility of DHHS' Head Start Bureau, Administration on Children, Youth and Families (ACYF).

Subsequently, under Title VIII of the Augustus F. Hawkins Human Services Reauthorization Act of 1990, the CCDP authorization was extended through 1994 and increased to $50 million per year, beginning in FY 1991. The FY 1994 appropriation for CCDP was $46.8 million. Also, an additional 10 centers were funded, beginning in 1992 and 1993.

Projects

The 24 original CCDP projects are located in all 10 DHHS regions and serve both urban and rural communities. They are administered by a wide range of grantee organizations, including hospitals, health agencies, universities, community action agencies, and county governments (see Exhibit 1 following the next page).

Goals

The goals of CCDP, as articulated in the act and the earlier Report of the Senate Committee on Labor and Human Resources (Senate Report 100-141), are as follows:

- To prevent educational failure by addressing the medical, psychological, institutional, and social needs of infants, young children, and their parents;
- To reduce the likelihood that young children will be caught in a cycle of poverty.
- To prevent welfare dependency and promote self-sufficiency and educational achievement.

To achieve these goals, the act funds "projects designed to encourage intensive, comprehensive, integrated and continuous support services which will enhance the physical, social, emotional and intellectual development of low-income children from birth to compulsory school age, including providing necessary support to their parents and other family members."

Eligibility and Program Requirements

To be eligible for CCDP, families must meet the following criteria:

- Have an income below the poverty line;
- Have an unborn child or a child under the age of 1; and
- Agree to participate for 5 years;

While programs may vary widely in emphasis and approach, all must:

- Intervene as early as possible in the child's life;
- Involve the whole family, including all preschool children in the family;
- Provide comprehensive services to address a wide range of needs;
- Provide continuous services from birth to compulsory school age; and
- Use services available locally and avoid duplication.

DHHS developed a list of core services that grantees must make available either through brokerage or, where necessary, directly. The modes of providing them are left up to individual projects.

For infants and young children, grantees must provide the following:

- Infant and child health services (including screening and referral);
- Child care that meets State licensing requirements;
- Early childhood development/education programs;
- Early intervention for children with or at risk for developmental delays; and
- Nutritional services.

For parents and other family members, grantees must provide the following:

- Prenatal care;
- Education in infant and child development, health, nutrition, and parenting;
- Mental health care;
- Substance abuse treatment;
- Vocational training;

Exhibit 1

CCDP Grantees—1989-1990

PROJECT NAME	CITY AND STATE
Project AFRIC Dimock Community Health Center	Roxbury, Massachusetts
Tennessee CARES Bureau of Educational Research and Services	Nashville, Tennessee
Windham County Family Support Program Brattleboro Town School District	Brattleboro, Vermont
Project Focus Grand Rapids Child Guidance Clinic	Grand Rapids, Michigan
Project CHANCE Project Teen Aid	Brooklyn, New York
West CAP Full Circle Project Western Wisconsin Community Action Agency	Glenwood City, Wisconsin
Parent-Child Resource Center Edward C. Mazique Parent-Child Center	Washington, DC
Project Family Arkansas Children's Hospital	College Station, Arkansas
Family Start Friends of the Family, Inc.	Baltimore, Maryland
Families Partnership CCDP City of Albuquerque	Albuquerque, New Mexico
Family Foundations Community Human Services University of Pittsburgh	Pittsburgh, Pennsylvania
Primero Los Niños La Clinica de Familia	Las Cruces, New Mexico
Toddlers, Infants, Preschoolers, and Parents (T.I.P.P.) Dade County Community Action Agency	Miami, Florida
Avance CCDP Avance, Inc.	San Antonio, Texas
Operation Family Community Action Council of Lexington-Fayette, Bourbon, and Nicholas Counties	Lexington, KY
ShareCare Program Day Care Association of Fort Worth and Tarrant County	Fort Worth, Texas

Exhibit 1 *(continued)*

PROJECT NAME	CITY AND STATE
Comprehensive Child Development Program Partnership Project Mid-Iowa Community Action	Marshalltown, IA
Community-Family Center for Persons with Disabilities Utah State University	Logan, Utah
Project Eagle University of Kansas Medical Center	Kansas City, Kansas
Conocimiento Southwest Human Development, Inc.	Phoenix, Arizona
Family Futures Clayton Foundation and Mile High Child Care	Denver, Colorado
ENRICH Venice Family Clinic	Venice, California
Little Hoop CCDP Little Hoop Community College	Fort Totten, North Dakota
Families First Children's Home Society of Washington	Auburn, Washington

- Adult education;
- Employment referrals; and
- Assistance in securing adequate income support, health care, nutrition, and housing.

Grantees are also required to establish advisory boards comprised of community service providers, business people, and CCDP family members and to ensure that adequate transportation exists for families to access needed services.

What Makes CCDP Different?

Many other programs offer services to children and/or families like the ones provided through CCDP. However, several program features and underlying principles together set CCDP apart from most existing programs.

First, parents rather than program staff set goals for their families and control the services they receive. All projects use a case management approach, assigning a particular staff member (or in some cases a team) to work with each family, help the family develop a viable plan for reaching its goals, and then help put the plan into action by linking the family to service providers inside and outside CCDP. The intent of this approach is threefold: (1) to individualize the configuration of services to fit each family's unique needs; (2) to build on each family's strengths, not merely remedy its weaknesses; and (3) to empower parents to take charge of their own futures and the futures of their children.

Second, CCDP focuses equally on the child and the family. The program serves children both directly (e.g., via early childhood education and health care screenings) and indirectly, through their parents (e.g., by improving parenting skills), as well as serves parents themselves (e.g., via adult education and various forms of counseling and rehabilitation). The underlying premise is that the family is the most critical part of the young child's environment. Therefore, strengthening families provides an essential context for effective early intervention. Helping families is helping children.

Finally, CCDP involves the whole community in serving children and families. Projects act as catalysts, bringing together different programs and agencies that deliver specific services. The purpose is not only to serve CCDP children and families better, but to help improve and integrate services to all low-income families in the community by creating awareness of their multiple needs and building linkages among service providers.

Other programs have incorporated these features in varying degrees, and CCDP has drawn on their examples and experiences. Among them are Head Start's Parent-Child Centers and Child and Family Resources Program and the privately funded, community-initiated Center for

Successful Child Development, also known as the Beethoven Project. Today, CCDP is the only federally funded program to implement the above features and principles on a national scale.

THE EVALUATIONS: LEARNING FROM THE CCDP EXPERIENCE

The act requires a continuing evaluation of CCDP projects "to determine their effectiveness in achieving stated goals, their impact on related programs, and their structure and mechanisms for delivery of services." To meet this legislative mandate, ACYF awarded two contracts—one to establish and maintain a management information system (MIS) and conduct a feasibility analysis and process evaluation; the other to assess the program's impact on children and families. The process evaluation is being conducted by CSR, Incorporated, which also provides assistance to ACYF in administering the projects and technical assistance to grantees. The impact evaluation is being conducted by Abt Associates Inc.

The evaluations are now in progress. This interim report is based on data collected when families had been in the program for 2 years or less. A final report to Congress will be delivered in 1996, after the end of the grant period.

Sites and Samples

Both evaluations focus on 21 of the initial 24 projects. Two were excluded because of difficulties in meeting the requirements of the research design and one because sufficient resources were not available for evaluation purposes.

To ensure the strongest possible research design, eligible families at each project site were randomly assigned at the time of enrollment to one of three groups: (1) a CCDP program group, (2) a control group, or (3) a replacement group. Across all sites there were about 2,200 families in each group. The initially assigned program and control groups essentially make up the sample for the impact study. The replacement group was used primarily to fill program slots vacated by families who dropped out or were terminated. This group played virtually no role in the impact study. In contrast, the process evaluation did not involve the control group, but it did include a large number of families from the replacement group who later joined the program.

Feasibility Analysis and Process Evaluation

Discussed below are the research questions and data sources used for the feasibility analysis and process evaluation.

Research Questions

The process evaluation asks the following: whether CCDP is serving the population for which it was designed, whether the program has been implemented as intended by Congress, whether the program has succeeded in enlisting and coordinating the services of existing community agencies, what the cost of the program is, what services families receive, how well these services match the families' needs and goals, and how much progress families are making in meeting their goals.

Data Sources

The process evaluation draws heavily on data from CCDP's MIS concerning families, programs, staff, collaborative arrangements, and service delivery. Additional data sources include qualitative reports by trained ethnographers; site visits by CSR staff and the Federal Project Officer; cost data from each program's third-year operating budget; quarterly reports submitted by the projects, which summarize progress made and areas needing improvement; and surveys of project directors and community leaders who serve on advisory boards.

Impact Evaluation

Discussed below are the research questions and data sources used for the impact evaluation.

Research Questions

To measure the effects of CCDP, the impact study compares program participants to the control group, whose members, because of random assignment, were similar to the CCDP group when the program began. The study asks whether, after a period of participation, CCDP parents differ from control parents in childrearing attitudes and skills, economic self-sufficiency, life management skills, and psychological and physical health. It also asks whether CCDP children and control children differ with respect to cognitive or language development, social-emotional development, or physical health and growth.

Data Sources

Effects on parents and families are assessed by direct observation of mother-child interaction, parental self-ratings, and an extensive parent interview that incorporates many survey items drawn from previous national studies. Effects on children are assessed via standardized developmental scales, which are administered by trained field staff, and also via parent ratings and interview responses (see Exhibit 2 following the next page for a list of topics covered and instruments used in the impact study).

INTERIM FINDINGS OF THE FEASIBILITY ANALYSIS AND PROCESS EVALUATION

The following are interim findings from the feasibility analysis and process evaluation:

- *CCDP is serving the families it was intended to serve.*—The act mandates that CCDP address the needs and goals of multirisk, low-income families throughout the United States. The program clearly is meeting this mandate.

  From its inception in October 1989 through March 1993, the program served a total of 3,300 families with 14,486 individual members. (This number includes all families from the initial program group, some of whom later dropped out, and families from the replacement group who filled the vacancies.) All 3,300 met income eligibility and other guidelines set out in the act. Average family income at enrollment was $5,800 per year. A majority of the families had received some form of social or welfare service previously. Upon entering the program, a majority were in need of better housing, child care, health care, transportation, or other basic necessities.

  About 85 percent of the families live in urban areas, including some of the poorest inner-city sections in country. The remainder live in rural areas with a host of social and economic problems.

  The ethnic composition of the group is 45-percent African-American, 27-percent Hispanic, 25-percent Caucasian, 2-percent Native American, and 1-percent Asian-American. English is the primary language for 84 percent of the families, Spanish for 14 percent, and a variety of Native American and Asian languages for the remainder.

  In 74 percent of the families, the primary caregiver (almost always the mother) is single, separated, divorced, or widowed. Primary caregivers average less than 11 years of schooling, and 37 percent have no high school diploma or other degree or certificate.

- *CCDP was implemented successfully but not easily.*—By 1992 all but one of the original CCDP projects were well established in their diverse communities and were delivering services on a regular basis. On average, it took projects 1 year or more to achieve this degree of stabilization.

  Grantees faced many challenging tasks in launching local CCDP projects: hiring staff; finding facilities; establishing working relationships with community agencies; recruiting eligible families for the program, control, and replacement groups; assessing families' goals; developing individualized plans; and beginning service delivery. Most

Exhibit 2

Impact Evaluation Outcomes and Measures

CHILD OUTCOMES	MEASURES
Cognitive Development	Bayley Scales of Infant Development, Kaufman ABC
Language Development	Peabody Picture Vocabulary Test
Adaptive Behavior	Scott-Hogan Adaptive Behavior Scale (parent rating)
Behavior Problems	Achenbach Child Behavior Checklist (parent rating)
Physical Health and Growth	Parent Interview
PARENT/FAMILY OUTCOMES	**MEASURES**
Parenting	
Mother-child interaction	Nursing Child Assessment Teaching Scale (direct observation)
Attitudes linked to abusive behavior	Bavolek Adolescent-Adult Parenting Inventory (self-rating)
Parent-child relationship	Parent Interview
Expectations for child	Parent Interview
Mother's Mental and Physical Health	
Physical health	Parent Interview
Depression	CES-D (self-rating)
Locus of control	Pearlin-Schooler Mastery Scale (self-rating)
Positive outlook	Rand Subscales (self-rating)
Problemsolving	Carver-Schrier COPE Subscales (self-rating)
Family Environment	
Environmental stress/family problems	NCAST Difficult Life Circumstances
Quality of home environment	HOME Scale
Stability of household and child's life	Parent Interview

projects attacked these tasks with high energy and high expectations of producing rapid change in families.

But as staff—mostly paraprofessionals at first—encountered the overwhelming problems of some families and the daunting demands of the job, problems quickly surfaced. Projects found themselves devoting too much staff time to a small group of families suffering multiple crises and too little to child development services and support for other families. A number of families, some of whom had been recruited hastily and were not really committed to CCDP, left the program; others were terminated by staff for nonparticipation or inappropriate behavior.[1] Also, staff turnover was high, making it difficult to establish the close relationships between families and case managers that is so critical to the success of CCDP.

Gradually, projects learned to balance the acute needs of the most vulnerable families with the broader mission of CCDP. Expectations were scaled down to more realistic dimensions, but services were scaled up as projects broadened their linkages with community agencies. Many projects brought in more professionally trained staff or consultants, particularly to strengthen the early childhood and parent education components of the program. Currently staff turnover appears to have stabilized. There is also some indication of a decline in the rate of families leaving the program.

Many projects also encountered gaps in services available locally, the most widespread being a lack of affordable, quality child care. Projects have addressed this problem with considerable success in a variety of ways: enlisting local parents to provide short-term care in their homes, helping CCDP mothers enter training to become licensed family day care providers, negotiating arrangements for school-based day care, purchasing blocks of slots in local child care facilities at discount rates, and operating their own child care centers.

This diversity of approaches is the rule, not the exception, for CCDP. Health care provides another example. Each project has developed its own model for helping families gain access to prenatal, well-baby, and acute care. Some projects rely on referral arrangements with local clinics or medical centers, some provide routine care onsite, many have links to private providers, and most rural projects provide health care during home visits to avoid long-distance transportation.

CCDP projects were diverse from the start, and they have become even more so as they have adapted to their community environments and the needs of the people they serve. It is essential to keep this heterogeneity in mind when reviewing later data on service delivery and program effects.

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[1] Some terminations occurred because families achieved their goals and/or no longer needed the program. For further discussion of positive terminations, see "Conclusions and Future Directions" at the end of this executive summary.

- *CCDP coordinated the efforts of thousands of service agencies nationwide and strengthened community services to low-income families.*—As the above child and health care examples suggest, CCDP succeeded in meeting its congressional mandate to avoid duplication of services and enlist existing agencies and providers wherever possible. CCDP projects across the country established more than 3,000 interagency agreements for provision of services to participating families. Of these, approximately three-fourths were long-term agreements with other community agencies, while one-fourth were shorter term agreements with individual service providers.

  In some communities, service networks already existed, and CCDP was able to integrate with and augment them. In other communities, services were fragmented, with poor communication and turf battles among various public and private agencies, and CCDP occasionally encountered initial skepticism from agency personnel. However, according to observations by onsite ethnographers and comments from advisory board members, even in these cases the project generally won acceptance over time.

  Overall, onsite observations suggest that CCDP succeeded (1) in raising awareness among service providers of the multiple, interrelated needs of the families they serve; (2) in promoting interagency cooperation; and (3) in increasing available services, thereby affecting not only CCDP families but other low-income families in the community as well. That such diffusion effects exist represents a major benefit of the program, although one that is extremely difficult to measure.

- *CCDP delivers a wide range of services to a high percentage of families.*[2]—Overall, CCDP projects are meeting their congressional mandate to deliver core services to families and children. Virtually all families listed by projects as currently active (99 percent) receive weekly or biweekly case management services[3]. In essence, receipt of case management services defines active participation in the program. Among these active families, percentages receiving other services through the program vary widely. In part, this variation reflects the fact that families receive some services outside the program and do not include these services among the goals they hope to achieve through CCDP. Percentages of active families receiving services through the program are summarized in Exhibit 3 following the next page.

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[2] Findings are based on MIS data collected during the first half of FY 1993 (October 1, 1992, to March 31, 1993), when programs were in their fourth year of operation—well past startup and almost all in a stabilized phase of operation. Percentages in the text are based on a total of 2,103 families enrolled during that period.

[3] The large difference between this percentage and the 58-percent figure in the impact study may be explained by several factors. The process study sample included only currently active families, virtually all of whom were receiving case management services, while the impact study sample included many families who had left the program. Also, process study data were contemporaneous records made by staff, whereas impact study data were parent reports based on recall over a 1-year period. Parents may have failed to recall some meetings with their case managers or may not have defined some contacts as "meetings."

- *A high percentage of CCDP participants make progress toward their personal goals.*—On entering the program, all participants, with the help of their case managers, identify specific goals they hope to achieve. These goals cover a wide spectrum, including improving their parenting skills, boosting their income, finding better housing, and securing better access to health care.

  From CCDP's inception through March 31, 1993, each of the 3,300 participating families received or utilized at least one service addressing each category of need it identified (except for two minor categories—clothing and home management skills).

  When asked whether they had achieved or made progress toward achieving personal goals, 80 to 95 percent of the participants said they had. For example, 94 percent said they had improved their parenting skills, 93 percent said they were making fuller use of community resources, and 86 percent said they had increased or were making progress toward increasing their incomes.

- *Parents generally are satisfied with CCDP, although they cite some aspects needing improvement.*—Parent satisfaction was assessed qualitatively by onsite ethnographers and generally found to be high. Parents at different sites tended to single out different aspects for praise, reflecting different program emphases from site to site. Complaints tended to focus on two shortcomings of the program: (1) inconvenient scheduling of child care, parenting classes, and other program activities and (2) inconsistent communication among staff and between staff and parents, often due to staff turnover.

- *CCDP costs about $8,000 per family per year, with wide site variations.*—Nonresearch costs of the program average $8,243 per family per year across all sites, or $2,137 per individual family member. Costs range widely from site to site, from a low of $4,592 per family per year to a high of $13,413.

PRELIMINARY FINDINGS OF THE IMPACT EVALUATION

Preliminary impact findings are based on data collected from parents and children within 1 month before or after each child's second birthday. The data collection period extended from late November 1991 through early 1993.

All effects of CCDP reported below reflect *statistically significant differences* between the randomly selected program and control groups.[4] Effects are reported for CCDP as a whole, weighting all sites equally.

As a context for understanding the substantive—as opposed to statistical—significance of the effects reported below, it is important to keep several points in mind:

- Because the impact evaluation sample was drawn from all families in the initial program and control groups, it includes families whose contact with CCDP varied widely—from families that terminated early, in some cases with little or no participation, to families that had been active for 2 full years. Complete adjustments have not yet been made for these variations. Therefore, the impact findings presented are conservative.
- CCDP originally was conceived as a 5-year program, and at most sites the first year was a startup period. Thus, the findings reported here reflect very early effects of program participation.
- Given the heterogeneity of CCDP projects, we may expect different effects at different sites, depending on the emphases and resources of particular projects. Combining sites gives an overall picture of CCDP's effectiveness but may do so at the cost of smoothing out these peaks and valleys.

The differences between the program and control groups, although generally variable, are particularly encouraging in light of the aforementioned considerations—all of which suggest that the findings may understate the full effects of CCDP at this particular point in the analyses. Differences between the two groups are as follows:

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[4] Initially there were 2,200 families in both the program and control groups. Data were collected from 61 percent of the focus children (1,286 program and 1,413 control children) and 64 percent of the parents (1,298 program and 1,529 control parents). About 16 percent of the children (705 in the 2 groups) had to be excluded because of an 8-month delay in approval of the data collection instruments, during which time the children became too old for testing with the approved instruments. Other families could not be located or refused to participate. Statistical procedures used in comparing program and control groups included an adjustment for background differences between the two groups not controlled by random assignment or differences introduced by selective attrition from the two groups (e.g., differences in ethnic distribution; education; family configuration; risk factors such as alcohol, tobacco, or drug use during pregnancy; and prematurity).

Exhibit 3

Percentages of Families Receiving CCDP Services

The percentages of families receiving services through CCDP are as follows:

- 80 percent of the families receive parent education in their homes once every 2 weeks (others receive parent education in classroom settings and some in both the home and a classroom);
- 75 percent of the children under age 5, including both focus children and siblings, receive screenings or assessments on an average of once every 3 months;
- Children in 77 percent of the families, including focus children and young siblings, receive in-home early childhood education (ECE) (once every 1½ weeks);
- 61 percent of the focus children and siblings under age 5 receive center-based ECE on an average of 2 days per week (many children receive both in-home and center-based ECE);
- 78 percent of the families receive health screening services averaging once per month;
- 70 percent of the mothers who become pregnant after entering the program receive CCDP-brokered prenatal care, averaging a little less than once per month;
- 71 percent of the parents receive some form of adult education (e.g., GED [graduate equivalency diploma] programs, English as a Second Language programs, vocational training, or career counseling);
- 57 percent of the families receive material or financial assistance (e.g., clothing, household items, emergency funds, child care subsidies, small business assistance, and low-interest loans);
- 33 percent of the families receive counseling or rehabilitation services relating to alcohol or drug abuse, family planning, marriage, mental health, nutrition, therapy (occupational, physical, or speech), stress reduction, and other topics;
- 43 percent receive housing assistance, including temporary housing and help in securing low-rent public housing, securing housing subsidies or mortgages, or with home improvements or utilities;
- 57 percent receive assistance related to nutritional needs (e.g., help in securing benefits under Federal programs, such as the Special Supplemental Food Program for Women, Infants, and Children [WIC] and food stamps);
- 23 percent receive help in securing medical benefits under medicare, medicaid, and State programs; and
- 28 percent receive help in securing income maintenance benefits under programs such as Aid to Families With Dependent Children (AFDC) and Supplemental Security Income.
- Many programs provide services (e.g., legal assistance, programs for teen parents, and social and recreational programs) outside the core group mandated by Congress.

- CCDP mothers have improved their parenting skills and attitudes:
    - — More CCDP mothers participate in parenting classes than control mothers;
    - — CCDP mothers and resident fathers in CCDP families spend more time with their children than those in the control group, and more CCDP families than control families have a father or father figure in the home;
    - — CCDP mothers have higher expectations about how far their children will go in school and how well they will do;
    - — Fewer CCDP mothers than control mothers express attitudes and beliefs that in past research have been linked to child abuse and neglect; and
    - — When observed in direct interaction with their children, CCDP mothers are more sensitive than control mothers to cues given by the children, respond more appropriately to signals of distress, and act in ways that tend to foster social-emotional growth.
- CCDP mothers are more aware and responsible about prenatal health. The small group of CCDP mothers who became pregnant while in the program did the following:
    - — Used alcohol less during pregnancy;
    - — Had slightly heavier babies; and
    - — Were somewhat less likely to require special care than their counterparts in the control group.
- CCDP parents are making progress toward economic and social self-sufficiency:
    - — More CCDP mothers than control mothers are enrolled in academic classes and vocational or job training classes or are working toward a trade certificate, a GED, or a bachelor's degree; and
    - — More working CCDP mothers than working control group mothers are satisfied with the amount of work they are doing, their pay, and their chances of moving up.

- CCDP children show improvements in cognitive and social-emotional development and physical well-being:
  - CCDP children score slightly higher than control children on the Bayley Scales of Infant Development;[5] and
  - CCDP children are reported by parents to exhibit more prosocial behavior (e.g., are more cooperative and follow rules better).
- CCDP families make more use of community resources than control families (CCDP and control families are assumed to be equally in need of services, since families were randomly assigned to the two groups; therefore, different rates of utilization may be interpreted as positive program effects, reflecting CCDP's success at brokering services for participants during the early enrollment years):
  - Substantially more CCDP mothers have met with social workers in the past year, including their CCDP case managers, than control mothers;
  - Slightly more CCDP children have seen a doctor for preventive health care than control children, and more CCDP children have completed immunization schedules than control children;
  - Substantially more CCDP children participate in early childhood programs than control children; and
  - More CCDP mothers use mental health services than control mothers.

CONCLUSIONS AND FUTURE DIRECTIONS

The most basic lesson to emerge from the evaluations so far is that the CCDP concept—individualized, family-focused, early intervention using existing community resources—is viable. Successful implementation of the program in a wide variety of urban and rural settings demonstrates that resources are there and can be marshaled on behalf of eligible families and children who were not served previously.

A more sobering lesson is that implementation is not easy. Projects have had to deal with a variety of local constraints and realities, especially the widespread lack of affordable quality child care, which is a prerequisite for parents' participation in program activities, adult education, and the workforce. Projects also have had to learn how to cope with multiproblem, crisis-prone families that drain staff time and energy.

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[5] A statistically significant difference at this very early stage in the measurement of children was not expected. The fact that this funding is statistically significant provides promise of potential long-term evidence of CCDP children's cognitive functioning.

Despite these difficulties, the program was successful overall in delivering congressionally mandated and other services to low-income families. The vast majority of families report that the program has helped them make progress toward their goals, and preliminary evidence indicates that there have been tangible, quantifiable improvements in family circumstances and children's development. Both process and impact findings were widespread and positive across many outcome areas. While some individual effects were small or nonexistent, the rich pattern of comprehensive results that appear at this early stage in the measurement of CCDP is both impressive and important.

Over the next 2 years, the impact study should provide a much more complete picture of the program's effects on families and children. It should allow us to measure the effects of long-term participation both on families and on children up to their entry in school. To the extent possible, given sample sizes and other methodological considerations, the study should reveal how effects vary with the intensity and duration of relevant services and with site-to-site differences in emphasis and resources.

Perhaps the most important policy issues to be addressed in the coming years are those of cost and cost-effectiveness. We need to examine closely the different components of program cost and the causes of the large site variations. To the extent possible, we need to relate these cost components to outcomes in order to understand how program dollars can be spent most effectively.

We also need to understand how outcomes depend on length of participation in CCDP. We already know from ethnographers' onsite observations that at least one-third of terminations in the early years of the program occurred because families met their goals and/or no longer needed the program. If large numbers of families can be served in less than the 5-year period envisioned in the original design of CCDP, it should be possible to reduce the program's per-family costs significantly. We also need to explore other possible avenues of cost reduction, such as limiting grantees' indirect costs.

Much has been learned, but much more remains to be learned. In this respect, CCDP is fulfilling one of its most important functions: that of a real-life laboratory for learning how to effectively serve some of the country's youngest and most disadvantaged citizens.